

Camp Name	☐ Camp Kanata ☐ Camp Sea Gull ☐ Camp Seafarer
Full Name	

THIS FORM TO BE COMPLETED BY A LICENSED PHYSICIAN

Weight		First	Name:	Date of Birth:	. //.	
Note: Some special conditions may be handled after individual discussions with Camp. PHYSICAL Weight	1.Is physically fit to en 2.Has no significant inf	ngage in strenuous activities with fectious condition that could be t	hout harm to himself/her transmitted to others	erself or others.	`amn	
CODE (Normal (X) Abnormal (Explain) Skin				Toutine operations and programs of c	anip.	
Weight	PHYSICAL					
Skin		Height	B.P/			
Chest	CODE () Normal (X) Abnormal (Explain)				
Chest	☐ Skin		☐ Nose			
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Heart			□			
Bars						_
Abdomen			□ -			_
Menstrual History (if applicable): Recommendations and Restrictions (diet, activity, etc.): Known Allergies: Does this individual have chronic medical problems, emotional difficulties, eating disorders or behavioral issues of which you are aware? If yes, please describe the condition: Does this individual take routine medications or nutritional supplements? If yes, please list medications or nutritional supplements. Note: A prescription must accompany any medications or supplements listed through camp's contracted pharmacy. To coincide with N.C. law for school enrollment, YMCA of the Triangle Overnight Camps REQUIRE THE FOLLOWING IMMUNIZATIONS. DTaP Polio (IPV/OPV) Hib Hepatitis B MMR (combined doses) Varicella Pneumococcal Conjugate Meningococcal Conjugate Meningococcal Conjugate Meningococcal Conjugate If APPLICABLE, INCLIDE IN ATTACHED Hep A INMUNIZATION RECORDS	<u> </u>					
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