Participant Name:________________________

2024 Season Program/Session______________

American Youth Foundation
Miniwanca | 231-861-2262 (phone) • 231-861-5244 (fax)
Merrowvista | 603-539-6607 (phone) • 603-539-7504 (fax)
www.ayf.com

AYF Camper Physical Exam Form

This must be completed and signed by child's primary licensed healthcare provider. This form verifies the date of child's last physical (*must be within 12 months of camp start date*) and healthcare provider recommendations for participation in the camp program.

***TO EXAMINING HEALTH CARE PROVIDER**: AYF Camp programs are physically and mentally strenuous at times. An individual with normal mental and physical capacity can usually expect to do well in our programs. Examples of activities in our programs include, but are not limited to, swimming, backpacking, sailing, remote camping, traversing varied terrain, exposure to the natural elements and using challenge courses of 50' high or greater. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitation of this participant in our program.*

Name of Child:________________________________ Date of Birth:________________________

Health History: (please check all that apply)

Allergies: Drug: ☐ Food: ☐ Environmental: ☐ Stinging Insects: ☐ None: ☐ ***Epi-pen required?*** Yes: ☐ No: ☐

Specify & Describe Reaction: ____

☐ ***Asthma*** (type):________________________________ Well controlled? _____________ Inhaler? Yes: ☐ No: ☐

Any recent injuries or other existing medical condition (chronic, mental health, or recurring illnesses?) Yes: ☐ No: ☐

If Yes, list here: (use back if necessary)____

Please list any active concerns or restrictions which would preclude this child from participating fully in a recreational program (diet, medical, swimming, athletic, psychological): None: ☐ or list here: ____

For participants with prescribed epi-pens or inhalers: Permission is required for the camper to carry their inhaler or epi-pen during camp. Please complete and sign the separate ***Permission to Self-Administer Emergency Medication form***.

Medications: List ALL medications, (including prescription, over-the-counter, sleep aids/vitamins/supplements, etc.) the camper will be taking at camp.

Please Note: *Routine medication times at camp are after meals and bedtime.* (Please attach additional paperwork if more space is needed).

Medication/Supplement Name	Dose (mg)	Frequency/Time(s)	Reason

Immunizations:

☐ Copy of immunizations are attached and are verified to be up to date.

Date of last Tetanus Toxoid Immunization:__________________________

TB Risk Assessment: Low Risk: ☐ High Risk: ☐

Test not necessary if risk deemed low. Test results:___________________ Date:_____________________________

How long have you known the participant?_____________________________ Date of Exam:________________________

HEALTHCARE PROVIDER SIGNATURE *(REQUIRED)*: ______________________ Name:___________________________

Address:____ Phone:___________________________

Today's Date: ______________________

Aspire Nobly • Adventure Daringly • Serve Humbly

Fall 2023