



Program/Session: _____

Year: _____

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 the participant'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 LICENSED 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. The camper must be able to get from one place in camp to another without requiring another camper/staff. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitations for this participant in our program.

Name of Participant: _____ Date of Birth: _____ Date of Exam: _____

Health History (please check all that apply)

Allergies: None Drug Food Stinging Insect Other **Epi-Pen Required?** Yes No

Specify Allergen & Describe Reaction: _____

Asthma: Yes No Type: _____ Well Controlled? _____ Inhaler? Yes No

For participants prescribed epi-pens or inhalers: Please complete and sign the attached **Emergency Medication Permission Form** (page 2)

Significant recent illness, injuries/fractures, concussions, seizures, headaches, bowel or bladder issues): _____

Chronic Medical Conditions: _____

Does the participant have any Developmental/Social/Emotional History (examples: anxiety, depression, suicidal ideation, ADHD, ASD, bedwetting, IEP or 504)? No Yes If yes, please describe: _____

Does the participant have a Vision or Hearing Impairment? No Yes If yes, please describe: _____

List Hospitalizations and/or Surgeries: _____

Restrictions: Are there any active concerns or restrictions which would preclude this child from participating fully in a recreational program at camp? (diet, medical, swimming, physical, psychological): None Yes (please explain): _____

Medications*

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

*Please note: Routine medication times at camp are after meals and at bedtime. If camper requires a dose of medication outside of these timeframes, parent/guardian must contact camp to ask about accommodations.

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

Immunizations

Date of last Tetanus Immunization: _____ Please attach an up-to-date immunization record.

TB Risk Assessment: Low Risk ___ High Risk ___

(Test not necessary if deemed low risk) Test Results: _____ Date of Test: _____

The above-named person has been determined to be physically and emotionally fit to participate in camp and camp activities without restrictions except as noted above.

Licensed Provider Signature (Required) _____ Date: _____

Licensed Provider Name (printed): _____ How long have you known camper? _____

Office Address: _____ Telephone: (____) _____

If you have any questions, please contact us at mvhealth@ayf.com (Merrowvista) or mwhealth@ayf.com (Miniwanca).
Once completed, please return form to guardian to upload to the camper's online AYF CampBrain portal.