COOPERSTOWN ALL STAR VILLAGE

Health Examination Form MUST be printed and filled out by a medical professional.

PATIENT FULL NAME _____ **DATE OF BIRTH** _____

REQUIRED FOR REGISTRATION, IMMUNIZATIONS MUST PRECEDE REGISTRATION ELIGIBILITY.
If this is not filled out by your medical provider, please upload immunization records.

1. **REQUIRED: TETANUS DIPHTHERIA TOXOID** (Minimum 2 doses, booster within 10 years)..... **DATE** _____
2. **REQUIRED: POLIO VACCINE** (Complete series of Oral/Salk)..... **DATE** _____

AND

MMR (Mumps, Measles, & Rubella) 1ST _____ 2ND _____

OR

1. **MUMPS VACCINE** DATE _____
2. **MEASLES VACCINE** 1ST _____ 2ND _____
3. **RUBELLA VACCINE** DATE _____

OR

1. **MUMPS VACCINE** DATE _____
2. **MEASLES VACCINE** 1ST _____ 2ND _____
3. **RUBELLA VACCINE** DATE _____

MEDICAL EXAMINATION – To be completed by licensed physician, physician's assistant, or nurse practitioner.
This examination must be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable and can be submitted in place of this section. Examination is for determining fitness to engage in strenuous activities. If this is not filled out by your medical provider, please upload immunization records.
CODE: S: Satisfactory - NS: Not Satisfactory - NE: Not Examined

HEIGHT _____ **WEIGHT** _____ **BLOOD PRESSURE** _____

EYES _____ TEETH _____ POSTURE/SPINE _____ THROAT _____ NOSE _____
GLASSES _____ HEART _____ SKIN _____ EXTREMITIES _____ HERNIA _____
EARS _____ ABDOMEN _____ ALLERGY _____ LUNGS _____

Recommendations and restrictions while in camp:
Special diet/Dietary restrictions _____
Special medications (identify) _____
Dispensing protocol _____
Can this camper participate in unrestricted recreational activity? Yes _____ No _____
If no, please explain _____
_____
Other _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

_____ _____
Examining Physician/PA/FNP Address

_____ _____

Prescription Medications (Only if patient takes medication)

(Must complete with patient's current regimen for both scheduled and PRN medications)

Physician Signature Required

ALL prescription medications MUST be checked in and stored in the infirmary except for EpiPens & Inhalers

DRUG	ROUTE	DOSAGE	SCHEDULE AND INDICATIONS	COMMENTS

Camper's Healthcare Provider (MD, NP, PA) _____ Phone _____

Address _____ License # _____

Physician's Signature _____ Date _____