2023 NAD Youth Leadership Camp
Health Form
(To be completed by camper's doctor/physician by May 1, 2023)

Physical exams made before July 22, 2022 will not be accepted.

Camper's Full Name: _____Date of Exam: _____

Birth Date: _____Height: _____ Weight: _____ Blood Pressure: _____

Gender: Male Female Other: _____Color of Hair: _____Color of Eyes: _____

Please check if the camper had any of the following health problems? If you checked yes, please explain:

Health History Information	**Explanation**
Yes No	**Allergies (Food, Drugs, Plants, Insects, etc.):**
Yes No	**Asthma (If yes, does he/she use an inhaler?):**
Yes No	**Back/Joint Pains:**
Yes No	**Cardiovascular Disorders:**
Yes No	**Cerebral Palsy:**
Yes No	**Chicken Pox:**
Yes No	**Clotting Disorders:**
Yes No	**Diabetes:**
Yes No	**Epilepsy/Convulsions:**
Yes No	**Eye Infections:**
Yes No	**Fainting:**
Yes No	**Frequent Ear Infections:**
Yes No	**German Measles:**
Yes No	**Hemophilia:**
Yes No	**Hernia:**
Yes No	**Measles:**
Yes No	**Meningitis:**
Yes No	**Menstrual Problems:**
Yes No	**Mumps:**

Camper's Full Name: _____

Yes No	**Nose Bleeds:**
Yes No	**Respiratory Infections:**
Yes No	**Rheumatic Fever:**
Yes No	**Severe Vision Problem:**
Yes No	**Stomach/Intestinal Problems:**
Yes No	**Urinary Tract Infections:**
Yes No	**Vaginal Infections:**
Yes No	**Mental Health Concerns (including ADHD, Depression, etc.):**
Yes No	**Major Surgeries:**
Yes No	**Serious Injuries:**
Yes No	**Physical Limitations:**
Other (specify):	
Please elaborate on any of the items checked above: (i.e. Allergic to bees – must have epi pen.)	
Chronic or Recurring Illnesses?	
Dietary Requirements or Restrictions? Food Allergies?	
Date of Last Tuberculin Test?	
Does the camper carry an epinephrine pen? For what?	
Additional physical/mental health considerations?	

Camper's Full Name:_____

Is the camper currently on medications? If yes, please include drug name, route, dosage, and schedule. If the staff member does not take the medicine, what will happen, including onset behavior?

_____

_____

Immunization History DPT	**Year/s of Immunization**	**Year/s of Last Booster**
Tetanus/Diphtheria		
Tetanus (alone)		
Oral Polio (Sabin)		
Injectable Polio (Salk)		
Measles (Rubeola)		
Measles (Rubella)		
Mumps		
Other (Specify)		

Is there a health problem that would prevent full participation in the camp program? No Yes

If yes, please describe:

_____

_____

Camper's Full Name: _____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason that would make it medically inadvisable for this camper to participate in physically strenuous activities.

Licensed Physician Name: (please print):_____

Street Address:

_____

_____

Daytime Phone Number(s):

_____

Emergency and/or Evening Phone Number(s):

_____

Licensed Physician's Signature and date:_____

Please email the completed form to: **nadylc@nad.org** with subject header "YLC Camper Completed Health Form."

If you cannot email, you can mail the completed form to:

NAD YLC
8630 Fenton Street, Suite 820
Silver Spring, MD 20910