YOUTH PROGRAM HEALTH EXAM/RECORD
FOR PARTICIPANTS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

___ Participant

___ Staff

PLEASE RETURN COMPLETED FORM TO:
The Children's Museum
950 Trout Brook Drive
West Hartford, CT 06119
Or fax to
(860) 232-0705

Name _____ Date of Birth _____ Phone _____

Parent/Guardian _____

Address _____Town _____ State ____ Zip _____

Emergency Contact _____ Phone _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam

_____ May participate in all program activities
_____ May participate except for: _____
_____

Medical information pertinent to routine care and emergencies: _____
_____

Is this individual taking prescription medication? ☐ Yes ☐ No
If yes, indicate prescription: _____

Does the individual have allergies? ☐ Yes Explain: _____ ☐ No

Is the individual on a special diet? ☐ Yes Explain: _____ ☐ No

FOR PARTICIPANTS ONLY: This participant is up to date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	**No**		**Yes**	**No**
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments:

Print Name of Medical Care Provider: _____

Medical Care Provider's Address: _____

City/Town _____ State _____ Zip Code _____

_____
Signature of Physician, APRN or PA

_____ _____
Date Form Signed Phone