CAMP HEALTH EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS

This side to be filled by parent or adult camper and checked with physician at time of examination.

Name____ D.O.B. _____________ Sex ______ Age ______

Last First Initial

Parent of Guardian (or Spouse) ____ Phone________________________

Home Address ____ Area/Number

Street & Number City State

Business Address ____ Phone _________________________

Street & Number City State Area/Number

If not available in an emergency notify:

1.____ Phone _______________________________________

Name Area/Number

____

Street & Number City State Zip

Or 2. ____ Phone ____

Name Area/Number

____

Street & Number City State Zip

Health History: (Check – giving approximate dates) **Allergies** **Diseases**

Frequent Ear Infections	____________	Hay Fever	______________	Chicken Pox	___________
Heart Defect/Disease	_______________	Ivy Poisoning, etc.	_________	Measles	___________
Convulsions	______________________	Insect Stings	_____________	German Measles	_______
Diabetes	__________________	Penicillin	_____________	Mumps	______________
Bleeding/Clotting Disorders	___________	Other Drugs	______________	Asthma	______________

Operations or serious injuries (dates) ____

Chronic or recurring illness____

Other diseases or details of above ____

Name of dentist/orthodontist:____ Phone__________________________

Name of family physician ____ Phone ___________________________

Do you carry family medical/hospital insurance?_________ If so, indicate:

Carrier: ____ Policy or Group #:________________

Any specific activities to be encouraged? ____

Or restricted?____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

Suggestions from parents:

____

____

Important – Must be Completed for Attendance

Parent's Authorizations.

This health history is correct so far as I know, and the person heir n described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the camp director to order, X-rays , routine testes and treatment for the health of my child and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and or anesthesia and or surgery for my child as named above.

Signature ____ **Witness** ____________________________ **Date**____________________

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses:

VACCINES	DATE OF BASIC IMMUNIZATION	DATE OF LAST BOOSTER
Diphtheria Pertussis (Whooping Cough) DPT* Tetanus Or	1 2 3	1 2
Tetanus Diphtheria TD* Or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given ___________ most recent		

Medical Examination---to be filled out by licensed physician.

This examination should be performed with 2-3 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination for determining fitness to engage in strenuous activities.

Code: V ---Satisfactory X---Not Satisfactory (explain) O----Not examined

Hgt.______________ Wt.____________ B. P.______________ Hct or Hgb. Test____________________Urinalysis_________________

Eyes_____________________
GLASSES_______________
Ears______________________
Nose______________________
Throat_____________________
Heart______________________
Genitalia___________________

Lungs___________________
Abdomen_________________
Hernia____________________
Extremities________________
Posture (Spine) _____________
Skin______________________

Allergy: (please specify)
____
____
General Appraisal:
____
____

Girls and Women

Has this person menstruated? _____________ If not has she been told about it? ___________________

If so is her menstrual history normal?__________________________Special considerations_______________________

Recommendation and restriction while in camp
Special Diet____
Current Medications____
Swimming Diving____
Strenuous Activity____
Other____

I have examined the person herein described an have review the heal history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

____M.D.
Examining Physician Signature

Telephone_____________________________ Address:____

Date:________________________________ ____