# Health History and Examination Form for campers and staff

## Part One: Health History (To be completed by parent/guardian or staff member)

Please Upload this form to your "Active" Camper Account: In Person forms cannot be accepted

Name of Camper: _____ Date of Birth: _____ Age: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Day Phone with Area Code: _____ Evening Phone: _____
____ Male ____ Female

Guardian Contact Information:
Name of Guardian: _____ Day Phone: _____
Evening Phone: _____ Email: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Name of Guardian: _____ Day Phone: _____
Evening Phone: _____ Email: _____
Street Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (Please list someone who can be reliably reached in the case of an emergency)
Name: _____ Relationship to camper: _____
Day Phone: _____ Evening or cell Phone: _____

Operations or serious injuries (dates) _____

Chronic or recurring illness or condition requiring medical treatment _____

Dietary Restrictions _____

Current Medications (please send labeled with instructions) _____

Other notable medical issues _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at camp _____

Current Doctor: _____ Phone _____

Current Dentist/Orthodontist: _____ Phone _____

Health History (check any applicable, list approximate date)

Heart Disease/Defect ____ Chicken Pox ____ Bed Wetting ____ Mumps ____
Convulsions ____ Diabetes _____ Asthma _____ Rheumatic Fever ____
Ear Infections ____ Kidney Issues _____ Bleeding/Clotting Disorder ____ Measles _____

Allergies:
Hay Fever _____ Poison Ivy ____ Penicillin _____ Other Drugs (list): _____
Insect Bites/Stings _____ Foods _____

Insurance Information:
Does your child have medical/hospital insurance? Yes/No

Insurance Carrier: _____ Policy Holder: _____ Insurance No. _____

Guardian Authorization (Required for those under age 18): The above child has permission to participate in all Camp activities, many of which are conducted in an outdoor environment which contain some level of risk, except as noted by myself and my physician. I give permission for camp medical personnel to provide routine health care, including administration of over-the-counter medications when necessary and prescription medication as instructed by the guardian or physician. I give Camp permission to release records necessary for insurance purposes. In the event that I cannot be reached during an emergency, I give the camp director permission to secure and administer treatment, including hospitalization, for the camper named above. I understand that my child cannot attend if he/she is not feeling well or has been exposed to a communicable disease. On arrival day, camp medical personnel have the right to refuse to admit campers who display symptoms of illness or disease.

Signature _____ Date Signed: _____

Part 2: Physical Examination: To be completed by Physician

Directions: Fill out Part 2 - The Health Exam. If the child has had a physical exam within the past 24 months, a new physical is not required. Please fill out the back of the form or attach a copy of the last physical. PLEASE DO NOT MAIL - RETURN TO PATIENT FOR HAND DELIVERY TO CAMP.

Immunization History (Check all applicable giving approximate dates - a record may be attached instead)

| Immunizations | Date | Booster | Immunizations | Date | Booster | Immunizations | Date | Booster |
|---|---|---|---|---|---|---|---|---|
| Measles, Mumps and Rubella (MMR) | 1<br>2 | | Diptheria and Tetanus Toxoids and Pertussis (DTaP/DTP/DT) | 1<br>2<br>3<br>4 | | Measles | 1<br>2 | |
| Inactivated Polio Vaccine (IPV) | 1<br>2<br>3 | | Td | 1<br>2<br>3 | | Mumps | 1 | |
| Oral Polio Vaccine (OPV) or Injectable Polio (Salk) | 1<br>2<br>3 | | Hepatitis B | 1<br>2<br>3 | | Rubella | 1 | |
| Mixed Schedule (IVP/OPV) | 1<br>2<br>3<br>4 | | Haemophilus Influenza b (HIB) | | | Other (most recent) | | |

Health Care Recommendations by Licensed Physician

In my opinion, the condition of this person ___does ___does not preclude his/her participation in an active camp program.

Height: _____ Weight: _____ Blood Pressure: _____

Is the individual under the care of a physician for any condition or impairment which may affect the activities of this individual while attending the camp? Please explain (include current medications and treatment)

_____

_____

Does this person have epilepsy? ___Yes ___ No  Does this person have diabetes? ___Yes  ____No

Recommendations and Restrictions While at Camp

Please list any camp activities from which the individual should be exempted for health reasons

_____

Please list any treatments or medications to be administered or continued at camp

_____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp

_____

_____

Medical Information pertinent to routine care and emergencies

_____

I have examined the person herein described and have reviewed his/her health history within the last 24 months. It is my opinion that she/he is physically able to engage in any camp activity except as noted above.

Examining Physician (Please Print): _____ Date Physical Performed: _____

Physician Signature: _____ Date Signed: _____

Office Address: _____

Office Phone Number with Area Code: _____

Date of Form Completion: _____ *by _____

*initial if completed by nurse or physician assistant