

HEALTH HISTORY AND EXAMINATION FORM

This form must be completed in order for campers and staff to attend camp.

This side is to be filled out by parents/guardian of minors or by adult staff members themselves.

Name _____ Birth Date _____ Sex _____ Age _____

Parent or Guardian _____

Home Address _____ Phone _____
Street and Number City State Zip

Business _____ Phone _____
Street and Number City State Zip

Second Parent/Guardian _____

Home Address _____ Phone _____
Street and Number City State Zip

Business _____ Phone _____
Street and Number City State Zip

If not available in an emergency, notify:

Name and Relationship: _____

Address _____ Phone _____
Street and Number City State Zip

Insurance Company and Policy Number _____

Family Physician _____ Phone _____

HEALTH HISTORY: <input type="checkbox"/> Respiratory: Pneumonia, Asthma, Bronchitis, Sinusitis <input type="checkbox"/> Recurrent Ear Infections <input type="checkbox"/> Gastrointestinal: Constipation, Abdominal Pain <input type="checkbox"/> Emotional Problems <input type="checkbox"/> Skin Problems <input type="checkbox"/> Convulsive Disorder <input type="checkbox"/> Kidney/Bladder Problems <input type="checkbox"/> Hearts Defects/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Other: _____	CURRENT HEALTH: <input type="checkbox"/> Respiratory Problem <input type="checkbox"/> Ear Infections <input type="checkbox"/> Gastrointestinal Problem <input type="checkbox"/> Diabetes <input type="checkbox"/> Emotional/Behavioral Problems <input type="checkbox"/> Skin Problems <input type="checkbox"/> Dietary Restrictions <input type="checkbox"/> Other: _____ FEMALES: Has she menstruated? _____ Has she been informed about it? _____	ALLERGIES: <input type="checkbox"/> Hay Fever <input type="checkbox"/> Ivy Poisoning <input type="checkbox"/> Insect Stings <input type="checkbox"/> Penicillin <input type="checkbox"/> Food (specify) _____ <input type="checkbox"/> Other (specify) _____ DISEASES: <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps
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MEDICATIONS: Each medication must be in original container with labeled instructions. Please bring essentials only.

<i>Medication</i>	<i>Instructions</i>

DOES THIS CHILD HAVE ANY SPECIAL NEEDS TO BE CONSIDERED WHILE PROCESSING THIS REGISTRATION?
 Please comment if YES:

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Authorization for Treatment:** I hereby give permission for the Camp Health Supervisor to administer medications and treatment for my child as named above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, and to order injections, anesthesia, or surgery for my child as named above.

Signature of Parent or Guardian: _____ Date: _____

IMMUNIZATION HISTORY

Written documentation of immunization or alternative proof of immunity is required for all campers and staff members. Please fill out chart or attach Physician's printout of Immunization History.

VACCINES		Year of Basic Immunization	Year of Last Booster
Diphtheria	or	1	1
Pertussis (Whooping Cough)	DPT	2	2
Tetanus		3	
Tetanus	or		
Diphtheria	TD		
Tetanus			
Oral Polio (Sabin) TOPV			
Injectable Polio (Salk)			
Measles (hard, red, Rubeola)	=		
Mumps	MMR		
Rubella (German, 3-day Measles)			
Haemophilus influenza b (HIB)			
Hepatitis B			
Other			

MEDICAL EXAMINATION

This examination should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable. (If camper or staff has had an exam within 24 months of camp, attach a copy of that exam to this form when sending it back). Examination is for determining fitness to engage in strenuous activities.

PLEASE CHECK IF NORMAL, OTHERWISE INDICATE CONCERNS/ABNORMALITY:

Heart _____ Eyes _____

Lungs _____ Glasses _____

Abdomen _____ Ears _____

Hernia _____ Nose _____

Extremities _____ Throat _____

Posture (spine) _____ Teeth _____

Skin _____ Feet _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Special Diet: _____

Strenuous Activity: _____

Other: _____

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

Licensed Physician's Signature

Date