

**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 \_\_\_\_\_

<b>HEALTH HISTORY:</b> <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: _____	<b>CURRENT HEALTH:</b> <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: _____  <b>FEMALES:</b> Has she menstruated? _____ Has she been informed about it? _____	<b>ALLERGIES:</b> <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) _____  <b>DISEASES:</b> <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. <b>Authorization for Treatment:</b> 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: _____
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## 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 Pertussis (Whooping Cough) Tetanus	1 2 3	1 2
Tetanus or Diphtheria	TD	
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard, red, Rubeola) = Mumps Rubella (German, 3-day Measles)	MMR	
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