

PLEASE USE BLACK INK

Camp Health Examination Record

(Must be completed for each camper AND staff member)

The camp office must receive this form before the first day of camp.

Part 1: To be completed by Camper or Staff Member (or, if under age 18, by Parent or Guardian)

Name _____
Last First Sex Age Date of Birth

Address _____ Telephone# _____

In an emergency, notify _____ Relationship _____

Check all applicable Chronic/Recurring Illness

Health History

- Chickenpox
- Measles
- Earaches
- German Measles
- Mumps
- Sinus
- Whooping Cough
- Other
- Heart

- Epilepsy
- Infections
- Diabetes
- Stomach
- Throat
- Rheumatic Fever
- Menstrual Problems

Allergies

- Hay Fever
- Insect Stings
- Asthma
- Drugs (specify)
- Food (specify)
- Ivy, Oak, etc.

Details of Above _____

Medication being taken (name and explain) _____

Operation, Injuries, restrictions (explain, give dates) _____

Continue explanations on reverse, if more space is needed

Authorization (required for all persons; parent/guardian signature if under age 18)

To the best of my knowledge, all information given is correct, and the person named above has permission to participate in all activities, except as noted by the examining physician or me. If 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, order injection, dispense those prescription medications authorized by the physician listed below, or authorized local or general anesthesia for surgery for the person named above.

Health Care Provider _____ Address _____ Phone# _____

Insurance Provider _____ Policy# _____ Phone# _____

Signature

Date Signed

Part II: Physician Examination (to be completed by a licensed Physician)

Date	Booster	Date	Booster	Date	Booster
Measles _____	_____	Diphtheria _____	_____	Polio _____	_____
Mumps _____	_____	Tetanus _____	_____	Hepatitis B _____	_____
Rubella _____	_____	Typhoid _____	_____	Other _____	_____

Height _____ Weight _____ B.P. _____ Skin _____ Nose _____

Eyes _____ Glasses _____ Contacts _____ Required _____ Condition _____

Ears _____ Hearing Right _____ Hearing Left _____

Throat _____ Teeth _____ Heart _____ Lungs _____ Skeletal _____

Abdomen _____ Genitalia _____ Hernia _____ Extremities _____

Test: Urinalysis Glucose _____ Albumin _____ TB Testing (type) _____

Restrictions / Limitations (including diet) _____

Medications _____

Recommendations _____

The above named person is in satisfactory condition, and may engage in all camp activities, except as noted

Physician's Name _____ State Licensed _____ License# _____

Address _____ Tel# _____

Signature

Date Signed