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

Health History

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

Chronic/Recurring Illness

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

Allergies

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

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 many engage in all camp activities, except as noted

Physician's Name ______________ State Licensed ______________ License# ______________

Address ______________________________ Tel# ______________

______________________________ ______________________________

Signature *Date Signed*