

Camp Health History and Examination Form For Children, Youth and Adults

Developed by the American Camping Association, Inc., in consultation with
The American Medical Association and the American Academy of Pediatrics

Cabin: _____

This side to be filled (missing IS between side and to) out by parents/guardian of minors or by adult campers/staff members themselves. (delete themselves?)

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial Mo/Day/Year

Parent/Guardian (Spouse) _____ Phone (____) _____

Home Address _____
Street & Number City State Zip

Business Address _____ Phone (____) _____
Street & Number City State Zip

Second Parent/Guardian or Emergency Contact: _____

Home Address _____ Phone (____) _____
Street & Number City State Zip

Business Address _____ Phone (____) _____
Street & Number City State Zip

If not available in an emergency, notify:
 Name _____ Phone (____) _____

Address _____
Street & Number City State Zip

Health History: Check, giving approximate dates

Frequent Ear Infections _____
 Heart Defect/Disease _____
 Convulsions _____
 Diabetes _____
 Bleeding/Clotting Disorder _____
 Hypertension _____

Mononucleosis _____
Diseases _____
 Chicken Pox _____
 Measles _____
 German Measles _____
 Mumps _____

Allergies

Hay Fever _____
 Ivy Poisoning _____
 Insect Stings _____
 Penicillin _____
 Other Drugs _____
 Asthma _____

Operations or serious injuries (dates): _____

Disability or chronic reoccurring illness: _____

Any specific activities to be encouraged or limited by physician's advice: _____

Dietary modifications: _____

Current Medication (**send with instructions**): _____

Other diseases or details of above: _____

Name of dentist/orthodontist: _____ Phone (____) _____

Name of Family Physician: _____ Phone (____) _____

Do you carry family medical/hospital insurance? _____ If so, indicate:

Carrier: _____ Carrier or Group #: _____

Suggestions or health related information for camp personnel: _____

(For Female): Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special considerations: _____

IMPORTANT: This box must be COMPLETED for attendance*

This health history form is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. **Emergency Authorization:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me/or my child and in the event 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, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied for use out of camp.

Signature of parent/guardian or adult camper/staffer _____

Witness: _____ Date: _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of Minor _____

* If for religious reasons you cannot sign this form, then the camp should be contacted for a legal waiver which must be signed for attendance.

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month and year) of basic immunization and most recent booster doses:

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (whooping cough)] DPT Tetanus	1. 2. 3.	1. 2. 3.
Tetanus		
Diphtheria] TD		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ most recent		

Health Examination by Licensed Physician:

I have examined the above camp applicant within the past two years. Date examined: _____

In my opinion, the above's condition does _____ / does not _____ preclude his/her participation in an active camp program.

This applicant is under the care of a physician for the following condition(s): _____

Current treatment (include current medications):

Explanation of any reported loss of consciousness, convulsions, or concussion: _____

Does applicant have epilepsy? Yes _____ No _____ Does applicant have diabetes? Yes _____ No _____

Recommendations and Restrictions While at Camp:

Any treatment to be continued at camp: _____

Any medications to be administered at camp (specific dosages): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drugs, plants, insects, etc.): _____

Additional Health Information:

Licensed Physician's Signature _____ Phone (____) _____

Address _____

Date of Completion _____ *By _____

*Initial if completed by nurse of physician's assistant.