

# Camp Health History and Examination Form For Children, Youth and Adults 2006

**Cabin:**

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

***This side to be filled out by parents/guardian of minors or by adult campers/staff members 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: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

suggestions or health related information for camp personnel: \_\_\_\_\_

**(For Female):** Has this person menstrated? \_\_\_\_\_ 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.
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 the 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 or physician's assistant