

# 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

- |   |                                  |                                   |   |  |   |  |
|---|----------------------------------|-----------------------------------|---|--|---|--|
| <input type="checkbox"/> Chickenpox     | <input type="checkbox"/> Measles | <input type="checkbox"/> Earaches | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Infections      | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Insect Stings   |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps   | <input type="checkbox"/> Sinus    | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Stomach         | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Drugs (specify) |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Other   | <input type="checkbox"/> Heart    | <input type="checkbox"/> Throat             | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ivy, Oak, etc. | <input type="checkbox"/> Food (specify)  |
|   |                                  |                                   | <input type="checkbox"/> Menstrual Problems |  |   |  |

### Allergies

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