CAMP HEALTH HISTORY AND EXAMINATION FORM FM108
FOR CHILDREN , YOUTH AND ADULTS

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

ROTARY DISTRICT 7430 – CAMP NEIDIG

IMPORTANT: PLEASE BRING THIS FORM COMPLETED TO CAMP

This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.

Name ______________________________ Birth Date __________ Sex _____ Age ________
Last First Initial

Parent or Guardian (or Spouse) ______________________ Phone ______________________
Area Code - Number

Home Address ____
Street & Number City State Zip Code

Business Address ____________________ Phone

Second Parent or Guardian or Emergency Contact: ______________________________

Home Address ______________________________________ Phone
Street & Number City State Zip Code

Business Address ______________________________________ Phone __________
Street & Number City State Zip Code

If not available in an emergency, notify:

Name ______________________________________ Phone __________

Address ____
Street & Address City State Zip Code

Health History*: (Check – giving approximate dates)*

Frequent Ear Infections	______	Mononucleosis	______	Allergies	
Heart Defect/Disease	______	Diseases		Ivy Poisoning, etc.	______
Convulsions	______	Chicken Pox	______	Insect Stings	______
Diabetes	______	Measles	______	Penicillin	______
Bleeding/Clotting Disorders	______	German Measles	______	Other Drugs	______
Hypertension	______	Mumps	______	Asthma	______

Operations or serious injury *(dates):* ______________________________

Disability or chronic or recurring illness: ______________________________

Dietary Modifications: ______________________________

Current medication *(send with instructions):* ______________________________

Other diseases or details of above: ______________________________

Name of dentist/orthodontist: ______________________________

Name of family physician: ______________________________

Date of last physical examination______________________

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 menstruated?: ______ If not, has she been told about it? ______

If so, is her menstrual history normal? ______ Special Consideration: ______________________

Important – This Box Must be Completed for Attendance*

This health history 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 or 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: ______________________________

(OVER)

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

IMMUNIZATION HISTORY:

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

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT* Tetanus or	1 2 3	1 2
Tetanus Diphtheria TD* or		
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. Date Examined:____

In my opinion, the above's condition does________/does not_____ preclude his/her participation in an active camp program.

The 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, convulsion 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 medication 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____

Street & Number City State Zip Code

Date of Form Completion________________ By_______________ *(initial if completed by nurse or physician's assistant)*