

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

*This is to be filled on by parents/guardians of minors or by adult campers/staff members themselves.*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian (or spouse) \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street & Number Apartment City State Zip Code

Business Address \_\_\_\_\_  
Street & Number Apartment City State Zip Code

Second Parent or Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_  
Street & Number Apartment City State Zip Code

Business Address \_\_\_\_\_  
Street & Number Apartment City State Zip Code

If either of above not available, in an emergency, notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street & Number Apartment City State Zip Code

Health History: Has/does the participant had/have (please check yes or no & give approximate date, explain any yes answers to questions marked with \* below)

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Frequent Ear Infections	[ ]	[ ]	[ ]	Mononucleosis	[ ]	[ ]	[ ]	Hay Fever	[ ]	[ ]	[ ]
Heart Defect/Disease*	[ ]	[ ]	[ ]	Chicken Pox	[ ]	[ ]	[ ]	Ivy Poisoning	[ ]	[ ]	[ ]
Convulsions*	[ ]	[ ]	[ ]	Measles	[ ]	[ ]	[ ]	Insect Stings	[ ]	[ ]	[ ]
Diabetes*	[ ]	[ ]	[ ]	German Measles	[ ]	[ ]	[ ]	Penicillin	[ ]	[ ]	[ ]
Bleeding/Clotting Disorders*	[ ]	[ ]	[ ]	Mumps	[ ]	[ ]	[ ]	Other Drugs	[ ]	[ ]	[ ]
Hypertension*	[ ]	[ ]	[ ]	Asthma *	[ ]	[ ]	[ ]				

Please explain any "yes" questions marked with an \* \_\_\_\_\_

Operations or serious injuries \_\_\_\_\_

Disability or chronic or recurring illness \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice? \_\_\_\_\_

Dietary Modifications \_\_\_\_\_

Current Medications (send with instructions) \_\_\_\_\_

Suggestions or other health related information you wish us to know: \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last Physical Exam \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone \_\_\_\_\_

## **IMPORTANT: PARENT/GUARDIAN MUST FILL OUT THE FOLLOWING INSURANCE SECTION**

**Do you carry family medical/hospital insurance? You must check one of the boxes YES [ ] NO [ ] If yes, indicate:**

Carrier \_\_\_\_\_ Policy or Group Number \_\_\_\_\_

\* For females: Has this person menstruated? \_\_\_\_\_ If not, have they been told about it? \_\_\_\_\_  
 If so, is her menstrual history normal? \_\_\_\_\_ Special consideration \_\_\_\_\_

## **IMPORTANT- PARENT/GUARDIAN & CAMPER MUST SIGN BELOW FOR CAMP ATTENDANCE**

This health history is correct as far as I know, and the person described herein described has permission to engage in all camp activities except as noted above.

I hereby give permission to for a Camp Wilbur Herrlich Staff member selected by the medical personnel and Camp Directors to provide for medical treatment at the Camp Physicians Office as needed. I also give permission for a designated Camp Wilbur Herrlich Staff member to pick up any prescriptions related to the care of my child at the pharmacy.

Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests and treatment for my child 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 injections and/or anesthesia and/or surgery for my child named above. This form may be photocopied for use out of the camp.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of Minor \_\_\_\_\_

**\*\*Your camper will NOT be registered for camp until this form is completely filled out and signed in the appropriate areas.\*\***

### IMMUNIZATION HISTORY

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

Vaccination	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)		
HIB (Haemophilus Influenza type B)		
HEP B		
Varicella (Chicken Pox)		
Tuberculin test given ____ (most recent)		

### **HEALTH EXAMINATION BY LICENSED PHYSICIAN**

I have examined the camp applicant \_\_\_\_\_ on Date \_\_\_\_\_

In my opinion, his/her condition does \_\_\_\_\_ does not \_\_\_\_\_ preclude him/her from normal camp activities.

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Current Treatment (include any medication): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion or contusion \_\_\_\_\_

Does applicant have epilepsy? Yes \_\_\_\_\_ No \_\_\_\_\_ Does applicant have diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_

Any treatments to be continued at camp: \_\_\_\_\_

Any medication to be administered at camp (specific dosage): \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any allergies (foods, drugs, plants, insects, etc... ) \_\_\_\_\_

### **FOR PHYSICIAN- PLEASE FILL OUT FOLLOWING INFORMATION**

Licensed Physicians Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

### **For Camp Use Only**

**Screening Record**

Date Screened \_\_\_\_\_ Medications Received \_\_\_\_\_

Observational Notes \_\_\_\_\_

Current health needs identified \_\_\_\_\_ Screened by \_\_\_\_\_