

**Health History and Examination Form for
Children, Youth and Adults Attending Camps**

Developed by American Camping Association, Inc. (Form FM08)

Northeast Rowing Center

P.O. Box 2060, Duxbury, MA 02331
tel 781-934-6192 • fax 781-934-5350
(During camp session fax to 207-655-4063)

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

Camper

Name _____ Birthdate ____/____/____ Sex ____ Age ____
Last First Initial mo day yr m/f

Parent or Guardian (or Spouse) _____

Home Address _____ Phone _____
Street & Number City State Zip Area-Number

Business _____ Phone _____
Street & Number City State Zip Area-Number

Emergency Contact

Second Parent or Other Person _____

Home Address _____ Phone _____
Street & Number City State Zip Area-Number

Business Address _____ Phone _____
Street & Number City State Zip Area-Number

If not available in an emergency, notify:

Name _____

Address _____ Phone _____
Street & Number City State Zip Area-Number

Health History: (check and approx. dates)

- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Convulsions
- _____ Diabetes
- _____ Bleeding/Clotting Disorders
- _____ Hypertension
- _____ Mononucleosis
- _____ Psychiatric Treatment

Has this camper ever required and psychiatric counseling or hospitalization? _____

Explain if yes _____

Operations or serious injuries (dates) _____

Disability or chronic or recurring illness _____

Activities encourage or limited by a physician _____

Dietary modifications _____

Current medications (send with instructions) _____

Other diseases or details of above _____

Suggestions on health related information _____

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Date of last physical examination _____

Diseases: (check and approx. dates)

- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mumps

Allergies: (check)

- Hay Fever
- Ivy Poisoning, etc.
- Insect Stings
- Penicillin
- Other drugs
- Asthma

Other (Specify) _____

Medical Insurance: Carrier _____ Policy/Group # _____

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. **Authorization for treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me or my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.*

Signature of parent or guardian or adult camper/staffer _____ Date _____

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

Signature of minor _____

Immunization History

Required immunizations must be determined locally. Please record the date of basic immunizations and most recent boosters.

Vaccines	Year of Immunization	Year of Booster
Diphtheria, Pertussis, Tetanus (DPT)		
Tetanus, Diphtheria (TD)		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German measles, 3-day measles)		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		

Health Care Recommendations 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.

Height _____ Weight _____ Blood pressure _____

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**

Recommendation 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: _____

Important - This Box Must Be Completed For Attendance

Licensed Physician's Signature

Address _____
Street and Number City State Zip Area-Number

Date of form completion: _____ * By _____
** Initial if completed by nurse or physician's assistant*