CAMP HEALTH HISTORY AND EXAMINATION FORM

Name____Birth Date______________Sex______Age__________
Last _________________________________ First___________________________________Initial__________
Second Parent/Guardian or Emergency Contact: ____
Home Address____
City_______________________________State____Zip Code____________Area Code/Number_________________
Business Address____
City_______________________________State____Zip Code____________Area Code/Number_________________
If Parent/Guardian not available, other Emergency Contact, state relationship to applicant_______________________
Name____ Area Code/Number__________________________
Address____
City_____________________________________ State________________ Zip Code_________________________

PHYSICIANS STATEMENT

I have examined the above named camp applicant. Date Examined:____
In my opinion, the camp applicant'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? (circle one) Yes No Does applicant have diabetes? (circle one) Yes No
Recommendations and Restrictions while at Camp:

Any treatment or medically prescribed plan to be continued at camp, or any medication to be administered at camp (include specific dosages):

Any allergies (food, drugs, plants & insects, etc) or any dietary restrictions:

Any Additional Health Information:

Licensed Physician's Signature*____

***Initial of Physician if completed by physician's assistant or nurse**
Address____
City___________________________________ State__________________ Zip Code______________________
Area code/ number____
Date Form Completed:____

Any other Confidential Information: **please use the reverse side if necessary**

Date____________________Signed____Parent/Guardian