

Child will attend camp the week(s) of: (check all that apply)  WEEK 1 (June 23 - 27)  WEEK 2 (June 30 - July 4)  WEEK 3 (July 7 - 11)  
 WEEK 4 (July 14 - 18)  WEEK 5 (July 21 - 25)  WEEK 6 (July 28 - August 1)  WEEK 7 (August 4 - 8)  WEEK 8 (August 11 - 15)

**YOUTH CAMP HEALTH EXAMINATION RECORD**

**TO BE COMPLETED BY PARENT OR GUARDIAN:**

NAME \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_  
(LAST) (FIRST) (STREET) (TOWN) (STATE) (ZIP)

IN EMERGENCY, NOTIFY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

**HEALTH HISTORY (CHECK)**

**ALLERGIES**

**CHRONIC/RECURRING ILLNESS**

- |   |                                  |  |  |                                   |   |
|---|----------------------------------|--|--|-----------------------------------|---|
| <input type="checkbox"/> CHICKENPOX     | <input type="checkbox"/> MEASLES | <input type="checkbox"/> HAY FEVER     | <input type="checkbox"/> INSECT STING    | <input type="checkbox"/> EARACHES | <input type="checkbox"/> THROAT PROBLEMS    |
| <input type="checkbox"/> GERMAN MEASLES | <input type="checkbox"/> MUMPS   | <input type="checkbox"/> ASTHMA        | <input type="checkbox"/> DRUGS (SPECIFY) | <input type="checkbox"/> SINUS    | <input type="checkbox"/> INFECTIONS         |
| <input type="checkbox"/> WHOOPING COUGH | <input type="checkbox"/> OTHER   | <input type="checkbox"/> IVY, OAK, ETC | <input type="checkbox"/> FOODS (SPECIFY) | <input type="checkbox"/> HEART    | <input type="checkbox"/> STOMACH            |
| DETAILS OF ABOVE _____                  |                                  |  |  | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> RHEUMATIC FEVER    |
| _____                                   |                                  |  |  | <input type="checkbox"/> DIABETES | <input type="checkbox"/> MENSTRUAL PROBLEMS |

MEDICATIONS BEING TAKEN (NAME & EXPLAIN) \_\_\_\_\_

OPERATIONS, INJURIES, SPECIAL RESTRICTIONS (EXPLAIN, GIVE DATES) \_\_\_\_\_

**IMMUNIZATIONS**

	<u>DATE</u>	<u>BOOSTER</u>
DIPHTHERIA	_____	_____
TETANUS	_____	_____
PERTUSSIS	_____	_____
POLIO	_____	_____
MEASLES	_____	_____
MUMPS	_____	_____
RUBELLA	_____	_____
OTHER	_____	_____

**PARENT OR GUARDIAN AUTHORIZATION (REQUIRED FOR ALL PERSONS UNDER AGE 18)**  
THIS HEALTH HISTORY IS CORRECT SO FAR AS I KNOW, AND THE PERSON NAMED ABOVE HAS PERMISSION TO PARTICIPATE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED BY ME OR THE EXAMINING PHYSICIAN. 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, AND ORDER INJECTION, ANAESTHESIA FOR SURGERY FOR THE PERSON NAMED ABOVE.

**SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**PHYSICAL EXAMINATION:**

**TO BE COMPLETED BY A LICENSED PHYSICIAN:** CODE: (1) Satisfactory (2) Not Satisfactory (0) Not Examined

HEIGHT _____	WEIGHT _____	B.P. _____	SKIN _____	NOSE _____
EYES _____	GLASSES _____	CONTACTS _____	REQUIRED _____	CONDITION _____
EARS _____		HEARING RIGHT _____		LEFT _____
THROAT _____	TEETH _____	HEART _____	LUNGS _____	SKELETAL _____
ABDOMEN _____	GENITALIA _____	HERNIA _____	EXTREMITES _____	

TESTS: URINALYSIS GLUCOSE? \_\_\_\_\_ ALBUMIN? \_\_\_\_\_ TUBERCULIN TESTING (TYPE) \_\_\_\_\_  
IF INDICATED, BLOOD COUNT \_\_\_\_\_

RESTRICTIONS, LIMITATIONS (INCLUDING DIET) \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

RECOMMENDATIONS \_\_\_\_\_

THE ABOVE-NAMED PERSON IS IN SATISFACTORY CONDITION AND MAY ENGAGE IN ALL CAMP ACTIVITES EXCEPT AS NOTED:

**DATE \_\_\_\_\_ EXAMINING PHYSICIAN \_\_\_\_\_**

**TELEPHONE \_\_\_\_\_ PRINT PHYSICIAN'S NAME \_\_\_\_\_**

**STATE LICENSED IN \_\_\_\_\_ LIC# \_\_\_\_\_ ADDRESS \_\_\_\_\_**

**MAIL OR BRING COMPLETED FORM TO THE CAMP OFFICE ON OR PRIOR TO THE FIRST DAY OF CAMP**