CAMP HEALTH HISTORY AND EXAMINATION FORM FM08
FOR CHILDREN, YOUTH AND ADULTS

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

RETURN TO: Blue Mountain Ranch
P.O. Box 146
Florissant, CO 80816

By ____________ (Date)

Camper's Name ____________ Date Examined ____________ Cabin or Tent ____________ Year ____________

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

Name ____________ (Last / First / Initial) Birth Date ____________ Sex ______ Age ______

Parent or Guardian (or Spouse) ____________ Phone ____________ (Area/Number)

Home Address ____________ (Street & Number / City / State / Zip Code)

Business Address ____________ (Street & Number / City / State / Zip Code) Phone ____________ (Area/Number)

Second Parent or Guardian or Emergency Contact: ____________

Home Address ____________ (Street & Number / City / State / Zip Code) Phone ____________ (Area/Number)

Business Address ____________ (Street & Number / City / State / Zip Code) Phone ____________ (Area/Number)

If not available in an emergency, notify:

Name ____________ Phone ____________ (Area/Number)

Address ____________ (Street & Number / City / State / Zip Code)

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

Frequent Ear Infections ______
Heart Defect/Disease ______
Convulsions ______
Diabetes ______
Bleeding/Clotting Disorders ______
Hypertension ______

Psychiatric Treatment ______
Mononucleosis ______

Diseases

Chicken Pox ______
Measles ______
German Measles ______
Mumps ______

Allergies

Hay Fever ______
Ivy Poisoning, etc. ______
Insect Stings ______
Penicillin ______
Other Drugs ______
Asthma ______

Has this camper ever required any psychiatric counseling or hospitalization? ____________

Operations or serious injuries *(dates)*: ____________

Disability or chronic or recurring illness: ____________

Any specific activities to be encouraged or limited by physician's advice: ____________

Dietary modifications: ____________

Current medication *(send with instructions)*: ____________

Other diseases or details of above: ____________

Name of dentist/orthodontist: ____________ Phone ____________ (Area/Number)

Name of family physician: ____________ Phone ____________ (Area/Number)

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 listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp:

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above.

Emergency Authorization: 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 the person 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.

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IMMUNIZATION HISTORY

Required immunizations 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 (Whopping 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 ____________
Area/Number

Address ______________________________________
Street & Number City State Zip Code

Date of Form Completion ____________ *By ____________

*Initial if completed by nurse or physician's assistant.