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

Name: _____ Date Examined: _____ Camp: _____ Year: _____

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.
(This side to be filled by parents/guardian of minors or by adult campers/staff members themselves.)

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Parent or Guardian (or Spouse) _____

Home Address _____ Phone _____
Street & Number City State ZIP Area/Number

Business _____ Phone _____
Street & Number City State ZIP Area/Number

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State ZIP Area/Number

Business _____ Phone _____
Street & Number City State ZIP Area/Number

It not available in an emergency, notify

Name _____

Address _____ Phone _____
Street & Number City State ZIP Area/Number

Health History
(Check: Give approximate dates.)

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

Diseases

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (Dates not needed)

_____ Hay Fever
_____ Ivy Poisoning. etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other *(Specify)*

_____
_____
_____

Operations or serious injuries *(dates)* _____

_____

Chronic or recurring illness or medical condition _____

_____

Dietary restrictions _____

Current medications *(send with instructions)* _____

Other diseases _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry family medical/hospital insurance? ☐ Yes ☐ No

It so, indicate: Carrier _____ Policy or Group # _____

Carrier Address _____

Suggestions on 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 herein described has permission to engage in all 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, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or 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 secure and administer treatment, including hospitalization, for the person named above. This completed form 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 or adult camper/staffer _____ Date _____

If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.

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	Yew of Last Booster
Diphtheria Pertussis (Whooping 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)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations 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.

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

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.)* _____

_____

Activities to be encouraged or limited _____

_____

Additional health information _____

Licensed Physician's Signature _____

Address _____ Phone _____

Street & Number *City* *State* *ZIP* *Area/Number*

Date of Form Completion _____ *By _____

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