2023 CAMPER HEALTH FORM

Parent/Guardian completes first page. First page must be submitted *including signature* for admission to camp.
Physician completes second page. A copy of immunizations and well-visit may be submitted in lieu of a physician's report.

Demographics:

PLEASE PRINT CLEARLY

Child's Name: ____
Last First MI

DOB: _______/_______/__________ Gender: _____________ Age: _______

Home Address: ____
Street & Number City State Zip

Parent / Guardian Name: ______________________________ Phone (Primary): ____________________

Email: ____ Phone (Secondary): _______________________

In an emergency, if parent/guardian is not available notify:

1. ______________________________________ __________________ __________________
Name Phone (Primary) Phone (Secondary)

2. ______________________________________ __________________ __________________
Name Phone (Primary) Phone (Secondary)

Child's Physician: ____ **Phone:** _______________________

Health History: (Check all that apply.)

General Health		Allergies		Disease	
Ear Infections	______	Hay Fever	_______	Chicken Pox	______
Asthma	______	Poison Ivy	_______	Measles	______
Seizures	______	Insect Stings	_______	German Measles	______
Diabetes	______	Penicillin	_______	Mumps	______
Autism	______	Other Medications (List): ______________________________			
ADHD	______	Other disabilities/disorders: ______________________________			

Date of Most Recent Medical Examination: ______________________ Examining Physician: __________________________

Operations (Specify year.): ____

Chronic or Recurring Illnesses: ____

Other Diseases or Details of Above: ____

Any activities to be restricted: ____

Parent Authorization

(Must be signed for admission to day camp.)

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 by me and the examining physician.

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, order injection, anesthesia, or surgery for my child named above.

____ ______________________
Parent/Guardian Signature Date

IMMUNIZATION HISTORY

Please list dates of basic immunizations and most recent booster doses. A printout of immunizations from a physician's office may be submitted in lieu of this portion.

ALL LISTED VACCINATIONS ARE REQUIRED FOR ADMITTANCE TO CAMP, as per the RCDOH.

Grades Kdg. and Up:
DTaP Series ______________________ DPT Booster ____________________ Hepatitis B _____________________

MMR (1st Dose) ______________________ MMR (2nd Dose) ______________________

Varicella (Chickenpox) ___________________ IPV (Polio) ________________ Polio Booster ___________________

Haemophilus Influenza (Hib) __________________ PCV _______________________

Grades 7 and Up:
Tdap Booster ______________________ MenACWY (Meningitis) ______________________

MEDICAL EXAMINATION

This examination should be performed within 12 months prior to camp. An examination for some other purpose within this period is acceptable. The examination is for determining fitness to engage in strenuous activities. Records from a previous well-visit may be submitted in lieu of this form.

HEIGHT __________ WEIGHT __________ B.P. ____________ HGB. TEST ____________ URINALYSIS __________

EYES ____________________________ EARS _______________________________ NOSE ____________________________

THROAT _________________________ HEART _____________________________ LUNGS ___________________________

EXTREMITIES ____________________ POSTURE (Spine) _________________________ SKIN _________________________

ABDOMEN __________________________ HERNIA ____________________________

ALLERGIES: (Please Specify) ____

GENERAL APPRAISAL: ____

FOR MENSTRUATING PERSONS:
Has this person Menstruated? [ ] Yes [ ] No If not, have they been told about it? [ ] Yes [ ] No
If so, is their menstrual history normal? [ ] Yes [ ] No

Special Considerations: ____

RECOMMENDATIONS & RESTRICTIONS WHILE IN CAMP:
Diet Restrictions:
____

Medications (Specify): ______________________________ Will this be sent to camp? [ ] Yes [ ] No

Is swimming restricted? ____

Is strenuous activity restricted? (Specify) ____

I have examined the person herein described & have reviewed his/her health history. It is my opinion that he/she/they is/are physically able to engage in camp activities, except as noted above.

____ _________________________
Signature or Stamp of Examining Physician Date