

Camper's Name _____

CAMP HEALTH EXAMINATION FORM FOR CAMPERS

(Please return form to Bournelyf Special Camp)

This side to be filled in by parent or guardian
and checked with physician at time of examination

It is recommended that a physical examination be conducted by your child's physician no more than 12 months prior to attending Camp program. This examination should indicate the health status of your child and the administration of necessary immunizations.

Camper's Name _____ Birth Date _____ Sex ____ Age _____

Parent or Guardian _____ Telephone _____

Address of Parent/Guardian _____
(number and street) (city) (zip code)

HEALTH HISTORY: Check if your child has had these illnesses or allergies.

ILLNESSES

ALLERGIES

(If unsure, consult physician)

Ear infections _____
Rheumatic fever _____
Convulsions _____
Diabetes _____

Chicken pox _____
Measles _____
German measles _____
Mumps _____
Asthma _____
Others _____

Hay fever _____
Poison ivy, etc. _____
Penicillin _____
Other drugs _____
Insect stings _____
Animals _____
Others _____

Describe allergies: _____

If Down Syndrome:

Atlanto-axial instability: Yes No Evaluation by X-ray: Positive Negative
(Circle one) (Circle one)

Date of X-ray: _____ Age at time of X-ray: _____

Operations or Serious Injuries _____

Chronic or Recurring Illnesses or other Diseases _____

PARENT'S AUTHORIZATION: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed 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 staff to administer first aid and the physician selected by the Camp Director to hospitalize and/or secure proper treatment for my child as named above.

SIGNATURE of Father or Guardian _____
(Both where applicable)
Mother or Guardian _____

Camper's Name _____

MEDICAL EXAMINATION (TO BE FILLED OUT BY LICENSED PHYSICIAN)

Height _____ Weight _____ Heart _____
Eyes _____ Lungs _____
Corrective lenses _____ Abdomen _____
Skin _____ Hernia _____
Ears _____ B.P. _____ Hgb. Test _____ Urinalysis _____
Nose _____ Extremities _____ Posture _____
Throat _____ Is this person subject to seizures? Yes ___ No ___ If yes,
Teeth _____ please give details: _____

IMMUNIZATION HISTORY:

This is a record of dates of basic immunizations and most recent booster doses:

DTP Series _____ Booster _____ Tetanus Booster _____
Polio OPV (Sabin) _____ Booster _____ Typhoid _____
Measles Vaccine (live) _____ Tuberculin test _____
German Measles (Rubella) _____ Mumps Vaccine (live) _____
Smallpox _____ Other _____

If Down Syndrome, Atlanto-axial subluxation? Yes _____ No _____
Cervical x-ray for Atlanto-axial subluxation: Positive _____ Negative _____

For girls and women:

Has this person menstruated? _____ If not, has she been told about menstruation? _____
Is her menstrual history normal? _____
Special Considerations: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Special Diet _____
Special Medicine (name) _____ Is parent sending it? _____
Medication Schedule _____
Restrictions on Strenuous Activity _____
Activities that should be encouraged _____
Other Concerns _____
General Appraisal: _____

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

Date _____
Signature of Examining Physician _____

Telephone _____ Address _____
