

APPENDIX G

CAMP HEALTH EXAMINATION FORM for CHILDREN, YOUTH and ADULTS

Developed by
AMERICAN CAMPING ASSOCIATION, INC.
in consultation with

The American Medical Association and The American Academy of Pediatrics

Camp Group _____
(For camp use only)

RETURN TO:
GREAT TIMES DAY CAMP, INC.
P.O. Box 449
WATERFORD WORKS, NJ 08089

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

Name _____ Birth Date: _____ Sex _____ Age _____
Last First Initial

Parent or Guardian (or Spouse) _____ Phone _____
Area and Number

Home Address _____
Street Number City State Zip Code

If not available in an emergency notify:

1. _____ Phone _____
Name

_____ Street and Number City State Zip Code

2. _____ Phone _____
Name

_____ Street and Number City State Zip Code

HEALTH HISTORY (Check - giving approximate dates)

| | <u>Allergies</u> | <u>Diseases</u> |
|-----------------------|---------------------------|----------------------|
| Ear Infections _____ | Hay Fever _____ | Chicken Pox _____ |
| Rheumatic Fever _____ | Ivy Poisoning, etc. _____ | Measles _____ |
| Convulsions _____ | Insect Stings _____ | German Measles _____ |
| Diabetes _____ | Penicillin _____ | Mumps _____ |
| Behavior _____ | Other Drugs _____ | Asthma _____ |

Operations or Serious Injuries (Dates) _____

Chronic or Recurring Illness _____

Other Diseases or Special Details of Above _____

Any Specific activities to be encouraged? _____

restricted? _____

IMPORTANT! *Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.*

Suggestions from Parents _____

PARENT 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 physician selected by the camp director to secure proper treatment for my child as named above.

Signature _____

IMMUNIZATION HISTORY

Required Immunization must be determined locally. 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 _____ |

MEDICAL EXAMINATION - *To be filled out by licensed physician*

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: _____ - Satisfactory
 X - Not satisfactory
 0 - Not examined

Hgt. _____ Wt. _____ B.P. _____ Hgb. Test _____ Urinalysis _____

| | |
|---------------|--------------------------|
| Eyes _____ | Extremities _____ |
| Glasses _____ | Posture (Spine) _____ |
| Ears _____ | Skin _____ |
| Nose _____ | Allergy: _____ |
| Throat _____ | Please Specify: _____ |
| Teeth _____ | _____ |
| Heart _____ | _____ |
| Lungs _____ | General Appraisal: _____ |
| Abdomen _____ | _____ |
| Hernia _____ | _____ |

(For Girls and Women)

Has this person Menstruated? _____ If not, has she been told about it? _____
If so, Is her menstrual history normal? _____ Special considerations: _____

RECOMMENDATIONS AND RESTRICTIONS while in camp

Special Diet _____

Special Medicine (name it) _____ Is parent sending it? _____

Swimming, diving _____

Strenuous activity _____

Other _____

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

Examining Physician

Telephone _____ Address _____

Date: _____