

# 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)

Allergies		Diseases	
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.

Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Examining Physician

Date: \_\_\_\_\_