

Camper Health History Examination Form

PLEASE PRINT ONE FORM FOR EACH ENROLLING CAMPER .

CAMPER'S NAME: _____ BIRTH DATE _____ SEX ___ AGE ___
Last First Initial

PARENT OR GUARDIAN _____

PHONE NO. _____
(H) _____ (O) _____ CELL OR BEEPER _____

NAME OF FAMILY PHYSICIAN: _____ PHONE NO. _____

DO YOU CARRY MEDICAL INSURANCE? ___ YES ___ NO NAME OF INSURANCE CARRIER _____

GROUP NAME _____ POLICY NO. _____

ADDRESS _____

Health History: (Check - Giving Approximate Dates)

| | |
|--|--|
| <input type="checkbox"/> Frequent Ear Infections _____ | <input type="checkbox"/> Bleeding/Clotting Disorders _____ |
| <input type="checkbox"/> Heart Defect/Disease _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Mononucleosis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Behavior _____ |

Diseases

| | |
|--|---|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> German Measles _____ |
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Mumps _____ |

Allergies

| | |
|--|--|
| <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Ivy Poisoning, Etc. _____ | <input type="checkbox"/> Other Drugs _____ |
| <input type="checkbox"/> Insect Stings _____ | <input type="checkbox"/> Asthma _____ |

OPERATIONS OR SERIOUS INJURIES (DATES) _____

DISABILITY OR CHRONIC OR RECURRING ILLNESS _____

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN'S ADVICE:

DIETARY MODIFICATION _____

CURRENT MEDICATION _____
(We cannot administer medication to your child/children.)

NAME OF DENTIST/ORTHODONTIST _____ PHONE NO. _____

SUGGESTIONS OR HEALTH-RELATED INFORMATION FOR CAMP PERSONNEL: _____