

**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

**Program:** \_\_\_\_\_

**RETURN TO:**

Sport EuroTour  
PO Box 408  
North Falmouth, MA 02556  
By May 1

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

Participant name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian (or Spouse) \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency notify: \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

**Health History: (Check — giving approximate dates)**

Conditions	Allergic Reactions***	Diseases
Migraine _____	Food (nuts, shellfish) _____	Chicken Pox _____
Heart Defect/Disease _____	Plants (poison ivy, etc) _____	Measles _____
Convulsions _____	Insect Stings _____	German Measles _____
Diabetes _____	Drugs _____	Mumps _____
Bleeding/Clotting Disorders _____	Other _____	Asthma _____

\*\*\* Severe allergic reactions – please give explanation and course of action \_\_\_\_\_  
\_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Chronic or recurring illness \_\_\_\_\_

Psycho-social conditions (ADD/depression/anxiety/food disorder, etc.) \_\_\_\_\_

If medication(s) will be taken during camp, indicate name of drug and dose \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Do you carry family medical/hospital insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, indicate below:

Carrier \_\_\_\_\_ Policy or Group number \_\_\_\_\_

**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's Signed 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.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and 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 for, and to order injection and/or anesthesia and/or surgery for my child as named above.

**Parent/Guardian Signature:** \_\_\_\_\_ Date \_\_\_\_\_

--- Important — Must be SIGNED & Completed for Camp Attendance ---

**IMMUNIZATION HISTORY Applicant Name:** \_\_\_\_\_

Required immunizations must be determined locally. Please record the date (month & year) of basic immunizations and most recent booster doses

Vaccines	Year of Basic immunization	Year of Last Booster
Diphtheria Pertussis (whooping cough)   DPT Tetanus or		
Tetanus Diphtheria   TD or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)	Height: _____	Weight: _____

**HEALTH EXAMINATION BY LICENSED PHYSICIAN WITHIN 12 MONTHS OF CAMP - I have examined the above applicant...**

In my opinion, the applicants condition does \_\_\_\_\_ / does not \_\_\_\_\_ preclude her / his participation in an active sports program.

Is there any physical and/or psycho-social conditions for which the applicant is under professional care: \_\_\_\_\_

\_\_\_\_\_

Current Treatment (include current medications): \_\_\_\_\_

Any activity or dietary restrictions: \_\_\_\_\_

Explanation of loss of consciousness, convulsion or concussion: \_\_\_\_\_

Does applicant have: Epilepsy: Yes \_\_\_\_\_ No \_\_\_\_\_ Asthma: Yes \_\_\_\_\_ No \_\_\_\_\_ Diabetes: Yes \_\_\_\_\_ No \_\_\_\_\_

Bleeding or clotting disorders: Yes \_\_\_\_\_ No \_\_\_\_\_ Heart defect/disease: Yes \_\_\_\_\_ No \_\_\_\_\_

Any allergies (food, drugs or insects): \_\_\_\_\_

Any medication to be administered (specific dosages): \_\_\_\_\_

Additional Health Information: \_\_\_\_\_

**\*\*\*LICENSED PHYSICIAN SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name of Physician (please print):** \_\_\_\_\_