



Health History and Examination Form for Children, Youth, and Adults

Part 1: Health History: To be completed by Guardian/Staff Member

Directions: Complete Part 1-Health History no more than 3 months before the start of camp. **MA State Law requires ALL campers and staff to have a current Health Form on file before they can participate at camp.** Part 2: Physical Examination is to be completed by Doctor. **DO NOT MAIL-BRING TO CAMP ON FIRST DAY** Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Camper Information

Name of Camper _____
 Street Address _____ City _____ State _____ Zip _____
 Day Phone with Area Code _____ Night Phone with Area Code _____
 Age _____ Date of Birth _____ Gender M/F _____ Cell Phone: _____

Guardian Information

Name 1st Guardian _____ Day Phone/Area Code _____ Night Phone /Area Code _____
 Street Address _____ City _____ State _____ Zip _____
 Name 2nd Guardian _____ Day Phone/Area Code _____ Night Phone /Area Code _____
 Street Address _____ City _____ State _____ Zip _____

Emergency Contact (Someone other than Parents in case parents cannot be reached)

Name _____ Relationship to Camper _____
 Day Phone with Area Code _____ Night Phone with Area Code _____

Operations or serious injuries (dates) _____
 Chronic or recurring illness or condition requiring medical treatment _____
 Dietary restrictions _____
 Current medications (**send with instructions**) _____
 Other diseases _____
 Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp _____

Current Doctor _____ Phone with Area Code _____
 Current Dentist/Orthodontist _____ Phone with Area Code _____

Health History (Check all applicable giving approximate dates)

Health Problems/Diseases (Please provide Dates)

- Heart Disease/ Defect _____
- Convulsions _____
- Bed Wetting _____
- Measles _____
- Asthma _____
- Ear Infection _____
- Bleeding/Clotting Disorder _____
- Chicken Pox _____
- Diabetes _____
- Mumps _____
- Measles _____
- Rheumatic Fever _____
- Kidney Trouble _____
- German Measles _____

Allergies

- Hay Fever _____
- Poison Ivy, etc. _____
- Other Drugs _____
- Foods _____
- Insect Bites/ Stings _____
- Asthma _____
- Penicillin _____
- Other _____

Insurance Information Do you carry family medical/hospital insurance? yes no

Insurance Carrier: _____ Policy Holder: _____ Insurance No. _____

Guardian Authorization (Required for persons 18 years of age and under) The person herein described has permission to engage in all Camp activities, many of which are conducted in an outdoor environment, except as noted by the examining physician and me. I hereby give permission to the medical personnel selected by the camp director to provide routine health care; administer certain over-the-counter medications when necessary and prescription medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director/staff to secure and administer treatment, including hospitalization, for the camper named above. I will make sure she/he will not attend if not feeling well or exposed to a communicable disease. On camp arrival day, the camp medical personnel have the right to refuse to admit a person to the camp who does not meet the acceptable health conditions e.g. temperature, contagious disease, etc. She/he has had no serious illness or operation since this doctor's examination. This completed form may be photocopied for trips out of camp.

Signature _____ Date Signed: _____

Part 2: Physical Examination: To be completed by Doctor

Directions: Fill out Part 2 – The Health Exam (within 24 months for of the last day of the camper’s session) if the patient has had a physical exam within the time period noted above, a new physical is not required. Just fill out the back of the form using that information or attach a copy of the last physical. **DO NOT MAIL –RETURN TO THE PATIENT** for hand delivery on the first day of camp.- We cannot be responsible for Health Forms that are mailed.

Immunization History (Check all applicable giving approximate dates) – *An immunization record can be attached*

Immunizations	Date	Booster	Immunizations	Date	Booster	Immunizations	Date	Booster
Measles, Mumps and Rubella (MMR) Vaccine:	1		Diphtheria and Tetanus Toxoids and Pertussis Vaccine: DTaP/DTP/DT	1		Measles	1	
	2			2			2	
				3				
				4				
inactivated polio vaccine (IPV)	1		Td	1		Mumps	1	
	2			2				
	3			3				
oral polio vaccine (OPV) or Infectable Polio (Salk)	1		Hepatitis B:	1		Rubella	1	
	2			2				
	3			3				
mixed (IVP/OPV) schedule	1		Haemophilus influenza b (HIB)			Other (most recent)		
	2							
	3							
	4							

For Females

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is the menstrual history normal? _____ Special Considerations: _____

Health Care Recommendations by Licensed Physician

In my opinion, the above's condition does does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

Is the individual under the care of a physician for any condition or impairment which may affect the individual's activities while attending the camp? *Please explain* (include treatment and current medications) _____

Does applicant have epilepsy? Yes no Does applicant have diabetes? yes no

Recommendations and Restrictions While at Camp

Please list any camp activities from which the individual should be exempted for health reasons _____

Any treatment to be continued at camp _____

Any medication to be administered at camp (please complete medication administration form for each) _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp _____

Medical Information pertinent to routine care and emergencies. _____

I have examined the person herein described and have reviewed her/his health history within the last 24 months. It is my opinion that she/he is physically able to engage in any camp activity except as noted above.

Examining Physician (Please Print): _____ Date Physical Performed: _____

Physician's Signature: _____ Date Signed: _____

Address: _____

Phone Number with Area Code: _____

Date of Form Completion _____ *by _____

*Initial if completed by nurse or physician's assistant.