



## 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 1<sup>st</sup> Guardian \_\_\_\_\_ Day Phone/Area Code \_\_\_\_\_ Night Phone /Area Code \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name 2<sup>nd</sup> 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.