

Camp Session attending

Cabin assignment

CAMP TRINITY 2009

P. O. Drawer 380
Salter Path, NC 28575

Health History and Examination form for Children, Youth, and Adults Attending Camp

CAMPER'S NAME _____

Birthdate _____ Sex _____ Age _____ Camper Social Security #: _____

Parent/Guardian _____

Phone: Day (____) _____ Night (____) _____ Cell (____) _____

Home Address _____ City _____ State _____ Zipcode _____

Vacation address

(if applicable) _____ City _____ State _____ Zipcode _____

Phone: (____) _____ Dates: _____

Second parent or Guardian or Emergency Contact:

Name _____ Relationship _____

Address _____ City _____ State _____ Zipcode _____

Phone: (____) _____

If not available in an Emergency,
notify: _____

Name/relationship

Family medical/hospital insurance: Carrier _____

Policy/Group# _____

Health History:

(Indicate with approximate date.)

.....Ear infections

.....Asthma

.....Convulsions

.....Diabetes

.....Heart defects/disease

.....Mononucleosis

Diseases:

.....Measles

.....German Measles

.....Chicken Pox

.....Mumps

Allergies(No dates needed):

.....Hay fever

.....Ivy Poisoning

.....Insect bites/stings

.....Penicillin

.....Other (specify)

OTHER:

Disabilities, chronic or recurring illness: _____

Operations or Serious injuries (Dates): _____

Mental or physical problems: _____

Dietary Modifications: _____

Problems with bed-wetting/comments: _____

Has the person presently or previously undergone psychiatric
and/or substance abuse treatment of any type? _____

Explain: _____

For Females Only

Has this person menstruated? _____

If no, has she been told about it? _____

Is her history normal? _____

Special considerations _____

Primary Care:

Name of camper's physician/phone _____

Name of dentist/phone _____

Parent comments and suggestions:

(activities to be encouraged, restricted, special concerns and explanations) _____

Important! This box must be completed for a camper to be admitted to camp on registration day.

This health history is correct to my knowledge and the person described herein has permission to engage in all prescribed camp activities, except as noted.

Authorization for Treatment: *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, transport, hospitalize, and order injection, X ray, routine tests, anesthesia, or surgery for the person named above.*

Signature of parent/guardian *or* adult camper

Date

MEDICAL EXAMINATION: TO BE COMPLETED BY A LICENSED PHYSICIAN

PLEASE NOTE: A health history/examination form must be completed and sent into the camp office **EACH YEAR** by a parent or guardian **30 days** before admission to a camp session.

A physician's examination for some other purpose within the past year is acceptable **if** the information requested on that form is the same as for this request. Examination is necessary in case of illness or accident and to determine fitness to engage in all camp activities

IMMUNIZATION HISTORY: (Dates of basic immunizations/most recent booster doses)

DTP series _____	Booster _____	German measles (Rubella) _____
Tetanus _____	Booster _____	Measles (Live) vaccine _____
Polio OPV (Sabin) _____	Booster _____	Mumps _____
Polio (Salk) _____		Tuberculin Test _____

GENERAL APPRAISAL:

Height _____	Weight _____	BP _____
Eyes _____	Glasses/contacts _____	Nose _____
Teeth _____	Braces _____	Throat _____
Ears _____		Heart _____
Speech _____	Hearing _____	Lungs _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

The applicant is under the care of a physician for the following condition(s): _____

Current treatment to be continued at camp _____

Specific medications: prescription and OTC, to be administered at camp _____

Swimming/Diving _____

Strenuous activity (describe) _____

Dietary restrictions _____

Allergies (food, drugs, plant, insect) _____

Additional health information _____

Licensed Physician's Signature

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

Signature of Examining Physician* (Please print or type name)

(____) _____ - _____
Telephone City State Zip

Date form completed _____ *By _____

*Initial if completed by nurse or physician's assistant

A note to parents:

Please notify the camp nurse at check - in if the camper has been exposed to or exhibits any symptoms of a communicable disease during the three weeks prior to camp attendance. Do not bring a sick child to camp. We reserve the right to send campers home who are sick on arrival.