



Mail this form back by June 1

2011 Camper Health History & Physical Examination Record

Please Mail To:
America's Camp
3 New King Street
White Plains, NY 10604

PARENT/GUARDIAN SECTION

- **THIS IS A DOUBLE-SIDED FORM. BOTH SIDES MUST BE COMPLETED.**
- All participants must, according to state regulations, have this form completed and signed to attend camp.
- A parent or guardian must complete the first page and sign the top part of the second page.
- A licensed physician must complete the second part of the form (bottom two-thirds of back page).
- Participants must have a physical conducted within 12 months prior to attendance, signed by a physician.

Camper's Name _____

Birthdate / / Age M or F

Parent/Guardian Name(s) _____

Allergies (List and describe reaction and management of the reaction)

GENERAL QUESTIONS (explain yes answers below):

Has/does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	9. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
5. Had any problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>	13. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
6. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>	14. Had emotional difficulties <u>within the past 2 years</u> for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions. Please also note any additional information regarding medical or psychological care that would help the camp care for this child:

SIGNATURE OF PARENT/GUARDIAN REQUIRED HERE: PLEASE READ CAREFULLY.

This health history is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted. **Authorization for Distribution of Prescriptions:** I hereby authorize **America's Camp** to administer, to the person herein described, the medications (listed above or prescribed while at camp by a physician), in accordance to the regulations listed in CMR101. **Authorization for Routine Medical Treatment:** I hereby authorize the Camp to give routine medical care as outlined in the standing orders for the camp. **Emergency Authorization:** I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment for 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. This form may be photocopied for use out of camp. I will assume all financial responsibilities for emergency treatment for my child not covered by the camper medical insurance.

► **Signature of Parent/Guardian** _____ **Date** _____

PHYSICIAN SECTION

The child's physician must fill out and sign this section. (Or, you may attach a copy of a signed physical done in the 12 months prior to camp which includes all this information.) The Immunizations section must also be completed by physician unless you attach an immunization history.

I examined this individual on _____ (month/day/year). BP _____ Weight _____ Height _____

In my opinion, the above applicant IS IS NOT able to participate in a full camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Modifications in activity at camp:

Medications to be administered at camp (name, dosage, frequency):

IMMUNIZATION HISTORY, Please give all dates of immunization (most recent starting on left):

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Physician's Signature: ► _____ **DATE:** _____

Printed Name _____ Title _____

Address _____ Phone _____