

**CAMP HEALTH HISTORY AND EXAMINATION FORM FM108  
FOR CHILDREN , YOUTH AND ADULTS**

Developed by  
American Camping Association, Inc. in consultation with  
The American Medical Association and the American Academy of Pediatrics

**ROTARY DISTRICT 7430 – CAMP NEIDIG**

**IMPORTANT: PLEASE BRING THIS FORM  
COMPLETED TO CAMP ON JUNE 13th**

*This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First Initial

Parent or Guardian (or Spouse) \_\_\_\_\_ Phone \_\_\_\_\_  
Area Code - Number

Home Address \_\_\_\_\_  
Street & Number City State Zip Code

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

Second Parent or Guardian or Emergency Contact: \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street & Number City State Zip Code

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street & Number City State Zip Code

If not available in an emergency, notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street & Address City State Zip Code

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

Frequent Ear Infections _____	Mononucleosis _____	<u>Allergies</u>
Heart Defect/Disease _____	<u>Diseases</u>	Ivy Poisoning, etc. _____
Convulsions _____	Chicken Pox _____	Insect Stings _____
Diabetes _____	Measles _____	Penicillin _____
Bleeding/Clotting Disorders _____	German Measles _____	Other Drugs _____
Hypertension _____	Mumps _____	Asthma _____

Operations or serious injury (dates): \_\_\_\_\_

Disability or chronic or recurring illness: \_\_\_\_\_

Dietary Modifications: \_\_\_\_\_

Current medication (send with instructions): \_\_\_\_\_

Other diseases or details of above: \_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_

Name of family physician: \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Do you carry family medical/hospital insurance? \_\_\_\_\_

If so, indicate:

Carrier: \_\_\_\_\_

Policy or Group # \_\_\_\_\_

Suggestions or health-related information for camp personnel: \_\_\_\_\_

(For Female): Has this person menstruated?: \_\_\_\_\_

If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_

Special Consideration: \_\_\_\_\_

**Important – This Box Must be Completed for Attendance\***

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me/or 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 me/or my child as named above. This form may be photocopied for use out of camp.

Signature of parent or guardian or adult camper/staffer: \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor: \_\_\_\_\_

**(OVER)**

\*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.

**IMMUNIZATION HISTORY:**

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

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) } DPT* Tetanus	1 2 3	1 2
or		
Tetanus } TD* Diphtheria }		
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)		

**HEALTH EXAMINATION BY LICENSED PHYSICIAN:**

I have examined the above camp applicant. Date Examined: \_\_\_\_\_

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

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

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

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

Does applicant have epilepsy? Yes \_\_\_\_\_ No \_\_\_\_\_ Does applicant have diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_

**Recommendations and Restrictions While at Camp:**

Any treatment to be continued at camp: \_\_\_\_\_

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

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any allergies (food, drugs, plants & insects, etc.): \_\_\_\_\_

**Additional Health Information:**

Licensed Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street & Number City State Zip Code

Date of Form Completion \_\_\_\_\_ By \_\_\_\_\_ (initial if completed by nurse or physician's assistant)