Health History and Examination Form for Children, Youth and Adults Attending Camps
Developed by American Camping Association, Inc. (Form FM08)

Northeast Rowing Center
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This side to be filled in by parents/guardian of minors or by adult campers/staff member.

Camper

Name ____________________ Birthdate ____/____/____ Sex ____ Age ____
Last First Initial mo day yr m/f

Parent or Guardian (or Spouse) ____________________

Home Address ____________________ Phone ____________
Street & Number City State Zip Area-Number

Business ____________________ Phone ____________
Street & Number City State Zip Area-Number

Emergency Contact

Second Parent or Other Person ____________________

Home Address ____________________ Phone ____________
Street & Number City State Zip Area-Number

Business Address ____________________ Phone ____________
Street & Number City State Zip Area-Number

If not available in an emergency, notify:

Name ____________________

Address ____________________ Phone ____________
Street & Number City State Zip Area-Number

Health History: *(check and approx. dates)*

- ❑________ Frequent Ear Infections
- ❑________ Heart Defect/Disease
- ❑________ Convulsions
- ❑________ Diabetes
- ❑________ Bleeding/Clotting Disorders
- ❑________ Hypertension
- ❑________ Mononucleosis
- ❑________ Psychiatric Treatment

Diseases: *(check and approx. dates)*

- ❑________ Chicken Pox
- ❑________ Measles
- ❑________ German Measles
- ❑________ Mumps

Allergies: *(check)*

- ❑ Hay Fever
- ❑ Ivy Poisoning, etc.
- ❑ Insect Stings
- ❑ Penicillin
- ❑ Other drugs
- ❑ Asthma
- ❑ Other (Specify)

Has this camper ever required and psychiatric counseling or hospitalization? ________

Explain if yes ____________________

Operations or serious injuries (dates) ____________________

Disability or chronic or recurring illness ____________________

Activities encourage or limited by a physician ____________________

Dietary modifications ____________________

Current medications (send with instructions) ____________________

Other diseases or details of above ____________________

Suggestions on health related information ____________________

Name of family physician ____________________ Phone ____________

Name of family dentist/orthodontist ____________________ Phone ____________

Date of last physical examination ____________

Medical Insurance: Carrier ____________________ Policy/Group # ____________

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. **Authorization for treatment:** *I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me or my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.*

Signature of parent or guardian or adult camper/staffer ____________________ **Date** ________

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

Signature of minor ____________________

Immunization History

Required immunizations must be determined locally. Please record the date of basic immunizations and most recent boosters.

Vaccines	Year of Immunization	Year of Booster
Diphtheria, Pertussis, Tetanus (DPT)		
Tetanus, Diphtheria (TD)		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella		
Mumps		
Rubella (German measles, 3-day measles		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years - _________ Date examined - ________________

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

Height _______________ Weight _______________ Blood pressure ___________________________

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**

Recommendation 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: ______________________________

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Licensed Physician's Signature

____

Address ______________________________ Phone ______________________

Street and Number *City* *State* *Zip* *Area-Number*

Date of form completion: ______________________ * By ______________________

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