CAMP HEALTH EXAMINATION FORM
For CHILDREN, YOUTH and ADULTS

RETURN TO:
WILBRAHAM RECREATION DEPT.
240 SPRINGFIELD ST.
WILBRAHAM, MA 01095

This side to be filled in by parent or guardian and checked with physician at time of examination.

Name _____ Birth date _____ Sex _____ Age _____
Last First Initial

Parent/Guardian _____ Phone _____

Home Address _____
Street and Number City State Zip Code

Business _____ Phone _____
Street and Number City State Zip Code

Second Parent/Guardian _____ Phone _____

Home Address _____
Street and Number City State Zip Code

Business _____ Phone _____
Street and Number City State Zip Code

If not available in an emergency notify:

Name _____ Home Phone _____ Other Phone _____
Name _____ Home Phone _____ Other Phone _____

Health History:
Check-give approximate dates

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorder
_____ Hypertension
_____ Mononucleosis

Diseases

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (dates not needed)

_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other (specify)
_____

Has this person ever required psychiatric counseling or hospitalization? _____
Explain _____
Operations or serious injuries (dates) _____
Chronic or recurring illness or medical condition _____
Dietary modifications _____
Current medications _____
Other diseases or details of above _____
Name of dentist/orthodontist _____ Phone _____
Name of family physician _____ Phone _____
Do you carry family medical/hospital insurance? [ ] Yes [ ] No
If so, indicate: Carrier _____ Policy/group # _____
Suggestions on 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 _____

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

PARENTS AUTHORIZATION

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 by me and the examining physician.

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot 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.

Signature _____ Date _____

Required information must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

Vaccines	Year of basic Immunization	Year of Last Booster
Diphtheria Pertussis (whooping cough) } DPT Tetanus or...	1. 2. 3.	1. 2.
Tetanus, Diphtheria = TD Or...		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tubercullin test given (most recent)		
Haemophilus Influenza b (HIB)		

MEDICAL EXAMINATION – *To be filled out by licensed physician.*
This examination should be performed within 24 months of arrival at camp. Examination for some other purposes within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

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 the applicant have epilepsy? [ ] Yes [ ] No Does the applicant have diabetes? [ ] Yes [ ] No

Recommendations and restrictions while in camp.
Any treatment to be continued ar camp _____
Any medication to be administered at camp (specific dosages) _____
Any medically prescribed meal plan or dietary restrictions _____
Any allergies (food, drug, plants, insects, etc.) _____

Activities to be encouraged or limited _____
Additional Health Information _____

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

Licensed Physician's Signature _____ M.D.

Address _____ Phone _____
Street & number City State Zip Code

Date _____ By* _____

* Initial if completed by nurse or physician's assistant