CAMP HEALTH EXAMINATION FORM

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

Name:_____ **Birth date:** _____**Gender: M:**___**F:**___ **Age:**_____
Last First M. Init.

Name of Parents/Guardians
(or spouse): _____**Phone:**(_____)_____

Home Address:_____
Street City State Zip

Email Address:_____

Church/Organization:_____

If not available in an emergency, please notify:

1. _____Phone: (___)_____
   Name Relationship
2. _____Phone: (___)_____
   Name Relationship

Check all that apply, giving approximate dates

Health History	Date	Allergies	Date	Diseases	Date
____ Frequent Ear Infections	_____	____ Hay Fever	_____	____ Chicken Pox	_____
____ Heart Defect/Disease	_____	____ Poison Ivy, etc.	_____	____ Measles	_____
____ Convulsions	_____	____ Insect Stings	_____	____ German Measles	_____
____ Diabetes	_____	____ Penicillin	_____	____ Mumps	_____
____ Bleeding/Clotting Disorders	_____	____ Other Drugs	_____	____ Asthma	_____

Allergies (describe reactions/treatment):
_____

Operations or serious injuries and dates:
_____

Chronic or recurring illnesses:
_____

Dentist/Orthodontist: _____Phone: (____)_____
Family Doctor: _____ Phone: (____)_____
Medical/Health Insurance Company:_____**Policy or Group #:**_____

IMPORTANT: *Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attending.*

Medications: ***All medications must be in original pill bottles!***

Medication 1: Dosage: Administer at: (Check all that apply) ☐breakfast ☐ lunch ☐dinner ☐ bed ☐ other Reactions:

Physician: RX#: Route of Administration: Date:

Medication 2: Dosage: Administer at: (Check all that apply) ☐breakfast ☐ lunch ☐dinner ☐ bed ☐ other Reactions:

Physician: RX#: Route of Administration: Date:

(If more medications are necessary please use the back of this form)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Parental Authorization. This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Camp staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Faith Bible Camp staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature:_____ **Date:**_____