

CAMP HEALTH EXAMINATION FORM

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

Last First M. Init.	Vame:		Birth date:	G	ender: M:F:_	Age:		
r spouse): Street Street City State Zip mail Address: Introch/Organization: Introch	Last	First	M. Init.					
Street City State Zip mail Address: murch/Organization: mot available in an emergency, please notify: 1. Name Relationship 2. Relationship Check all that apply, giving approximate dates Health History Date Hary Fever Chicken Pox Prequent Ear Infections Hay Fever Chicken Pox Diseases Convulsions Insect Stings German Measles Convulsions Insect Stings German Measles Diabetes Plediding/Clotting Disorders Penicillin Mumps Bleeding/Clotting Disorders Other Drugs Asthma Dereations or serious injuries and dates: Periodical/Health Insurance Company: PORTANT: Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attent Medications: Administer at: breakfast bunch Medications: Administer at: breakfast bunch bed other Reactions: ysician: RX#: Route of Administration: Date: Administer at: breakfast bunch bed other Reactions: ysician: RX#: Route of Administration: Date: Administer at: breakfast bunch bed other Reactions: ysician: RX#: Route of Administration: Date: Administer at: breakfast bunch bed other Reactions: ysician: RX#: Route of Administration: Date: Administer at: breakfast bed other Reactions: ysician: RX#: Route of Administration: Date: Administer at: breakfast bed other Reactions: ysician: RX#: Route of Administration: Date: Administer at: breakfast bed other Reactions: ysician: RX#: Route of Administration: Date: IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE rental Authorization. This health history is correct so far as I know, and the person described herein has permission to eng prescribed activities. In the event of an emergency, thereby give permission to the physician selected by the Faith Bible Ca for the properties and treatment for the health off my child, in the event that I cannot be reached in an emergency in the present and the person described herein has permission to eng prescribed activities. In the event of an emergency, thereby give permission to the physician selected by the Faith Bible Ca in the properties and t				DI				
Street City State Zip mail Address: murch/Organization: mot available in an emergency, please notify: 1.	r spouse):		Phone:()					
not available in an emergency, please notify: Name								
not available in an emergency, please notify: 1.	Street			City	State	Zip		
Name Relationship Date Diseases Poison Ivy, etc. Measles German Measles Diabetes Penicillin Mumps Bleeding/Clotting Disorders Penicillin Mumps Asthma Diabetes Penicillin Mumps Diabetes Penicillin Mumps Diabetes Penicillin Diabetes Penicillin Mumps Deteroring illnesses: Interview Phone: Phone	nail Address:						_	
Name Relationship Check all that apply, giving approximate dates Health History Date Allergies Date Diseases Date Perquent Ear Infections Hay Fever Chicken Pox Heart Defect/Disease Poison Ivy, etc. Measles German Measles Diabetes Penicillin Mumps Bleeding/Clotting Disorders Other Drugs Asthma Marging describe reactions/treatment): perations or serious injuries and dates: hronic or recurring illnesses: entist/Orthodontist: Phone: Date Phone: Medications must be in original pill bottles! Administer at: breakfast lunch Medications: Administer at: breakfast lunch dedication 1: Dosage: (Check all that apply) dinner bed other Reactions: Posician: RX#: Route of Administration: Date: IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE Affor the Bottle Canfil Bib Ca aff 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 hereby give permission to the physicians alected by the Faith Bible Ca aff 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 hereby give permission to the physicians alected by the Faith Bible Ca aff 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 afforms the control of the canfil 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 afforms the cancel of an emergency is the permission to the physician selected by the Faith Bible Ca aff 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 afforms the cannot be reached in an emergency	hurch/Organization:						_	
Name Relationship	not available in an emergen	cy, please notify:						
Phone: Phone: Phone: Phone: Phone: Phone: Phone: Phone: Phone: Phone: Phone:			D.1.:		Phone: ()			
Name Check all that apply, giving approximate dates			Relatio	onship	Phone: ()			
Health History Date Allergies Date Diseases Diseases Diseases Prequent Ear Infections Hay Fever Chicken Pox			Relationship					
Frequent Ear Infections								
Heart Defect/Disease		Date		Date			Date	
Convulsions						_		
Diabetes Penicillin Mumps Asthma Bleeding/Clotting Disorders Other Drugs Asthma Bleeding/Clotting Disorders Asthma Bleeding/Clotting Disorders Other Drugs Asthma Bleeding/Clotting Disorders Asthma Bronic or recurring illnesses: Bentist/Orthodontist: Phone: Phone: Bentist/Orthodontist: Bentist/Orthodontist. Bentist/Orthodontist: Phone: Phone: Administration Bentistian Bentistan Bentistian Bentistan Bentistian Bentistian Bentistian Bentistian Bentistian Bentistian								
Bleeding/Clotting Disorders Other Drugs Asthma llergies (describe reactions/treatment): perations or serious injuries and dates: hronic or recurring illnesses: entist/Orthodontist: Phone:								
Phone:						_		
perations or serious injuries and dates: hronic or recurring illnesses: entist/Orthodontist:			Other Drugs		Asthma	_		
hronic or recurring illnesses: entist/Orthodontist:	nergies (describe reactions/ti	reatment):						
rentist/Orthodontist: Amily Doctor:	perations or serious injuries	and dates:						
rentist/Orthodontist: Amily Doctor:	<u> </u>							
Phone:					Phone: ()			
Policy or Group #: MPORTANT: Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attem Medications: All medications must be in original pill bottles! Administer at: breakfast lunch ledication 1: Dosage: (Check all that apply) dinner bed other Reactions: nysician: RX#: Route of Administration: Date: Administer at: breakfast lunch ledication 2: Dosage: (Check all that apply) dinner bed other Reactions:	amily Doctor:				Phone: ()			
Medications: All medications must be in original pill bottles! Administer at: breakfast lunch		mpany:		Policy o	r Group #:			
Medications: All medications must be in original pill bottles! Administer at: □breakfast □lunch Dosage: (Check all that apply) □dinner □ bed □ other Reactions: Nysician: RX#: Route of Administration: Date: Administer at: □breakfast □lunch Dosage: (Check all that apply) □dinner □ bed □ other Reactions: Administer at: □breakfast □lunch Dosage: (Check all that apply) □dinner □ bed □ other Reactions: Nysician: RX#: Route of Administration: Date: (If more medications are necessary please use the back of this form) IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE Arental Authorization. This health history is correct so far as I know, and the person described herein has permission to engil prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen							— endino	
Administer at:	in citirii (1.1 tease nougy as					s pi toi to uti	citating	
Administer at: Breakfast Bunch Bed Other Reactions:			Administer at:	hreakfast	lunch			
Administer at:	ledication 1:	Dosage:	(Check all that apply)	dinner	hed other	Reactions:		
Administer at:	editation 1.	Dobage.	(Check all that apply	<u> </u>	oca — omer	Treactions.		
In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Caraff 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 are medications are medication and the person described in an emergency are medication.	nysician:	RX#:	Route	of Administra	tion:	Date:		
Indedication 2: Dosage: (Check all that apply) dinner bed other Reactions: Note			Administer at:	hreakfast	lunch			
IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE arental Authorization. This health history is correct so far as I know, and the person described herein has permission to eng I prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff 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	Indication 2:	Doggga				Pagations:		
(If more medications are necessary please use the back of this form) IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE arental Authorization. This health history is correct so far as I know, and the person described herein has permission to eng I prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen	ledication 2.	Dosage.	(Check all that apply) Шаппет Ш	i bed 🗀 other	Keactions.		
IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE arental Authorization. This health history is correct so far as I know, and the person described herein has permission to eng I prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen	nysician:	RX#:	Route	e of Administra	ation:	Date:		
arental Authorization. This health history is correct so far as I know, and the person described herein has permission to eng I prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen		(If more medication	ns are necessary please us	se the back of	this form)			
arental Authorization. This health history is correct so far as I know, and the person described herein has permission to eng I prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen		IMPODTANT. M	HICT DE COMDI ETED	EOD ATTEN	DANCE			
l prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Faith Bible Ca aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen						,		
aff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergen								
so give permission to the physician selected by the Faith Bible Camp staff to hospitalize, secure proper treatment for, to order				hospitalize, se	cure proper treatme	ent for, to ord	der	
ejection and/or anesthesia and/or surgery for my child as named above.	jection and/or anesthesia and/o	or surgery for my ch	ild as named above.					

Parental Signature: ______ Date: