For Office Use

Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

Suggested for resident camp use.

Developed and approved by
American Camping Association®
American Academy of Pediatrics

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Year

Cabin or Group

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social security number of participant _____ Gender: ☐ Male ☐ Female

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business address _____ Phone _____

If not available in an emergency, notify:

Name _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

▶ **Photocopy of front and back of health insurance card must be attached to this form.**

Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

Name

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

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Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____

_____ _____

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

_____ _____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

_____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs

☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products

☐ Other (describe) _____

_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____
Address _____
Name of family dentist/orthodontist _____ Phone _____
Address _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

_____

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

_____

_____

Medications to be administered at camp (name, dosage, frequency)

_____

_____

Any medically-prescribed meal plan or dietary restrictions

_____

_____

Known allergies

_____

_____

Description of any limitation or restriction on camp activities

_____

_____

Additional information for health care staff at the camp

_____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

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Screening Record

Date screened _____ Time _____ am pm

Meds received _____

_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs identified _____

_____

Observational notes _____

_____

Screened by _____

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