

**Camp Health History & Examination Form
For Children, Youth, & Adults**

Developed by: American Camping Association, Inc. in consultation with
The American Medical Association and the American Academy of Pediatrics
Edited by the Woodson YMCA, 2003

Return this form by deadline to
Camp Registrar
Woodson YMCA
707 Third Street
Wausau, WI 54403

**This side to be filled in by parents/guardian of minors
Or by adult campers/staff members**

Name _____ Birth Date ____/____/____ Sex M / F Age ____

Parent or Guardian (or Spouse) _____ Phone (____) _____

Home Address _____
Street & Number _____ City _____ State _____ Zip _____

Work Address _____
Street & Number _____ City _____ State _____ Zip _____

If different from above:

Second Parent or Guardian (or Spouse) _____ Phone (____) _____

Home Address _____
Street & Number _____ City _____ State _____ Zip _____

Work Address _____
Street & Number _____ City _____ State _____ Zip _____

Health History: (circle & give approximate date or information)

Bleeding/Clotting Disorders	no / yes, _____	Diseases		Allergies	
Heart Defect/Disease	no / yes, _____	Chicken Pox	no / yes, _____	Asthma	no / yes, _____
Convulsions	no / yes, _____	German Measles	no / yes, _____	Hay Fever	no / yes, _____
Diabetes	no / yes, _____	Measles	no / yes, _____	Insect Stings	no / yes, _____
Frequent Ear Infections	no / yes, _____	Mumps	no / yes, _____	Ivy Poisoning, etc.	no / yes, _____
Hypertension	no / yes, _____			Other Drugs	no / yes, _____
Mononucleosis	no / yes, _____			Penicillin	no / yes, _____

Other diseases or details other than above: _____

Operations or serious injuries include dates: _____

Disability or chronic or recurring illness: _____

Dietary modifications: _____

Current medication (send with instructions): _____

Date of last physical examination: _____

Suggestions or health related information for camp personnel: _____

Female Only: Has this person menstruated? No / Yes Special Considerations: _____
If Yes, is her menstrual history normal? No / Yes If No, has she been told about it? No / Yes

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.

Emergency Authorization: I hereby give permission to the medical personnel, selected by the camp director, to order X-rays, routine tests and treatment for me/for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied for use out of camp.

Signature of parent or guardian or adult camper/staffer _____ **Date:** ____/____/____

Only If Applicable: If for religious reasons you cannot sign above, sign here, which is necessary for attendance, indicating medical/legal waiver.
Signature for religious medical/legal waiver _____ Date: ____/____/____

This side to be filled in by Licensed Physician

Health Examination by Licensed Physician:

The applicant is under the care of a physician for the following condition(s): None / explain: _____

Current treatment (include current medications): No / Yes, _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does applicant have epilepsy? No / Yes Does applicant have diabetes? No / Yes

Recommendations and restrictions while at camp:

Any treatment to be continued at camp: No / Yes, _____

Any medication to be administered at camp (specific dosages): No / Yes, _____

Any medically prescribed meal plan or dietary restrictions: No / Yes, _____

Any allergies (food, drugs, plants and insects, etc.): No / Yes, _____

Additional Health Information: No / Yes, _____

I have examined the above camp applicant. In my opinion, the above camper's condition
(circle one) **does** OR **does not** preclude his/her participation in an active camp program.

Important – This Box Must Be Completed for Attendance

Licensed Physician's Signature: _____ **Date:** ____ / ____ / ____

Phone: (_____) _____ Address: _____
(Area Code) Number Street and Number City State Zip

If form was completed and or signed by nurse or physician's assistant, he/she **Initials** here: _____