

For Office Use

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

FM 08N

Dates of Camp Attendance \_\_\_\_\_

Mail this form to the address below by \_\_\_\_\_ (date)

**Suggested for resident camp use.**

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

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.

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\*

<p><b>Parent/Guardian Authorizations:</b> 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.</p> <p>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,</p> <p>Signature of parent/guardian or adult camper/staffer _____</p> <p>Printed Name _____</p>	<p>referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.</p> <p>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.</p> <p>_____</p> <p>Date _____</p>
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<p>I also understand and agree to abide by any restrictions placed on my participation in camp activities.</p> <p>Signature of minor or adult camper/staffer _____</p> <p>Date _____</p>
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\*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Year

Cabin or Group

Name

## 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)

_____
_____
_____