CAMP HEALTH EXAMINATION FORM
for CHILDREN, YOUTH, and ADULTS

RETURN TO:
ARROWHEAD DAY CAMP
240 Dutton Mill Road
West Chester, PA 19380-6601

RETURN BY 6/10

Or Fax (Both Sides)
(610) 695-8118

This side to be filled in by parent and checked by physician at time of examination.

Name _____ Birth Date _____ Sex ____ Age _____
Last First Initial

Parent or Guardian (or Spouse) _____ Phone # _____

Home Address _____
Street & Number City State Zip Code

Mother's Work Phone# _____ Father's Work Phone# _____

Mother's Cell Phone# _____ Father's Cell Phone# _____

If not available in an emergency, please notify:

1. _____ Phone # _____
Name/Relationship Area Code & Number

_____
Street & Number City State Zip Code

or 2. _____ Phone # _____
Name/Relationship Area Code & Number

_____
Street & Number City State Zip Code

Family Physician _____ Phone # _____

Medical Insurance _____ Company Policy No. _____

HEALTH HISTORY:

Child had physician's examination in last ❑ Year ❑ 2 Years ❑ 3 Years ❑ More ❑ Never

I consider the child's health ❑ Excellent ❑ Above Average ❑ Below Average ❑ Average ❑ Poor

Sunburns easily ❑ Yes ❑ No

Behavioral/Emotional problems we need to be aware of _____

_____

_____

Chronic or Recurring illness _____

Any specific activities to be restricted? _____

Important: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

PARENT'S AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician.
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 order injection, anesthesia or surgery for my child as named above.

Signature _____ Date _____ (over) ▸▸

I hereby give the camp permission to administer children's dosage of over the counter medication, (Tylenol, Tums,Benadryl), as deemed necessary by the nursing staff. **Please check:** ❑ **Yes** ❑ **No**

THIS SECTION TO BE FILLED IN BY CAMPER'S PHYSICIAN

IMMUNIZATION HISTORY - *Attach history or complete below*

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DPT, Td or Tdap (circle most recent) Date _____

Polio _____ Booster _____ Tuberculin Test _____

MMR#1 _____ #2 _____ Hepatitis B #1 _____ #2 _____ #3 _____

Varicella #1 _____ #2 _____ Other _____

MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

This examination should be performed within twelve months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: √ **-** Satisfactory **X** - Not Satisfactory (explain) **O** - Not Examined

Eyes _____ Ears _____ Throat _____ Glasses _____ Nose _____ Teeth _____

Extremities _____ Heart _____ Abdomen _____ Skin _____ Posture (spine) _____ Lungs _____

Hernia _____ Height _____ Weight _____ Hgb. Test _____ Urinalysis _____ B.P. _____

Allergy (s): Please specify:

MEDICATIONS BEING TAKEN _____

Please list ALL medications (Prescription, Non-prescription, and Emergency). Bring enough medication to last the entire time at camp. Keep it in the original package or 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

This person takes medications as follows: (include Insulin, Glucagon, Epipen, etc.)

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 _____

***Recommendations and restrictions while in camp**

Special Diet _____

*Swimming/Diving _____

*Strenuous activity/Heat Tolerance _____

Other _____

General Appraisal: _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

_____
Examining Physician

Telephone _____ Address _____

Date _____ _____