

Camper Name: _____

Health History

Indicate the following by entering an approximate date of last occurrence. Leave blank if not applicable.

Disease	Date	Disease	Date
Chicken Pox:	_____	Asthma:	_____
Measles:	_____	Hepatitis A:	_____
German Measles:	_____	Hepatitis B:	_____
Mumps:	_____	Hepatitis C:	_____

Allergies (Non-Dietary)

Ivy Poisonings, etc. Insect Stings Penicillin

Other (Specify) _____

Dietary Allergies

Peanut Shell Fish Citrus Wheat

Tree Nuts Flat Fish Mustard Whey

Other Dietary Allergies or Comments. Include description of critical allergic reactions.

Operations or Serious Injuries (with Dates)

Chronic or Recurring Illnesses:

Other Diseases or Additional Information About the Above:

Camper Name: _____ -

Immunization

Please record the date (month and 4-digit year) of basic immunizations and the most recent booster doses.

DTP					
TD (Tetanus/Diphtheria)					
Tetanus					
Polio					
Haemophilus, Influenza B					
Hepatitis B					
Varicella (Chicken Pox)					
MMR					
or Measles					
or Mumps					
or Rubella					

TB Maritoux Test	Date: _____	<input type="checkbox"/> Test was positive
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Has this person ever tested positive for HIV: Yes No

Mental/Emotional Health

Please check any that apply and explain below:

- Diagnosis of Attention Deficit Disorder (ADD or AD/HD)
- Diagnosis of depression, OCD, panic/anxiety disorder
- Significant learning or processing challenge (disability)
- Currently seen by professional for mental/emotional health concerns
- Treated with medications for mental/emotional problem
- Other emotional health concern)

Comments: _____

If any of the above are checked, please have the mental health professional send a written statement to the camp, describing:

- a) The condition and treatment plan, including any medications
- b) Any behavior at camp that indicates to the staff that the applicant needs a professional referral
- c) A recommendation for participation in our camp program

If medication for any of the above has been prescribed, also provide:

- d) Certification that the applicant has been taking the same medication at the same dose for 3 months prior to the start of camp
- e) If (d) is not true, a detailed explanation for the change in medication.

Camper Name: _____-

Medications

Send enough medication to last while your child is at camp. Keep it in the original packaging. If a prescription, the label should include the drug, dosage, time(s) of delivery and the physician's name.

If the applicant is to take medications routinely at camp, including over-the-counter or other non-prescription drugs, please enter these medications below.

Medication (or common name)	Dosage	Delivery				
1. _____	_____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	
Physician: _____			<input type="checkbox"/> Taken regularly	<input type="checkbox"/> As needed		
Physician's Phone: _____			<input type="checkbox"/> While at camp	<input type="checkbox"/> Until ___ / ___		
2. _____	_____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	
Physician: _____			<input type="checkbox"/> Taken regularly	<input type="checkbox"/> As needed		
Physician's Phone: _____			<input type="checkbox"/> While at camp	<input type="checkbox"/> Until ___ / ___		
3. _____	_____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	
Physician: _____			<input type="checkbox"/> Taken regularly	<input type="checkbox"/> As needed		
Physician's Phone: _____			<input type="checkbox"/> While at camp	<input type="checkbox"/> Until ___ / ___		
4. _____	_____	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	
Physician: _____			<input type="checkbox"/> Taken regularly	<input type="checkbox"/> As needed		
Physician's Phone: _____			<input type="checkbox"/> While at camp	<input type="checkbox"/> Until ___ / ___		

Special Medication Instructions:

Camper Name: _____

Medical Insurance and Prescription Cards

Please photocopy both sides of your family’s insurance and prescription card and attach here. The prescription card will be used if your child requires prescription medications this summer.

MAKE SURE COPIES ARE LEGIBLE

Medical Insurance Card (Front)

Medical Insurance Card (Back)

Prescription Card (Front)

Prescription Card (Back)

Note: If you have more than one child at camp, you only need to supply this page one time.

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



Camp Arrowhead

FOR BOYS

Physician's Examination

Patient: _____, _____
 (Last) (First)

Address: _____

City/State/Zip _____

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.

Codes: V- Satisfactory X – Not Satisfactory O – Not examined

Height: _____ Weight: _____ Heart: _____ BP: _____

Hct/Hgb Test: _____ Urinalysis: _____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Lungs: _____

Glasses: _____ Extremities: _____ Genitalia: _____ Abdomen: _____ Hernia: _____

Skin: _____ Posture: _____

Allergy (Please specify): _____

General Appraisal: _____

Is this person up to date on all routine childhood immunizations? Yes No

Date of last tetanus shot: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Special Diet: _____

Current Medications: _____

Swimming/Diving: _____

Strenuous Activity: _____

Other: _____

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

 (Examining Physician) _____ (Telephone)

Date _____