

DAY CAMP ADULT HEALTH EXAMINATION RECORD

Name (Last, First, Initial)		Email		
Address		City	State	Zip
Home Phone (____) _____		Date of Birth		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Cell Phone (____) _____				
Work Phone (____) _____				
Emergency Contact Person & Relationship		Home Phone (____) _____		
		Cell Phone (____) _____		
		Work Phone (____) _____		

ALLERGIES

0 Animals 0 Food 0 Insect Stings 0 Medicine/Drugs 0 Plants 0 Seasonal 0 Other

Describe reaction and management of this reaction: _____

MEDICATIONS

Please list ALL medications (including over-the-counter non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle.:

NUTRITION

_____ I eat a regular, varied diet.

_____ I have the following dietary restrictions _____

CHRONIC CONCERNS

0 Asthma	0 Headaches/Migraines	0 Sleep problem
0 Diabetes	0 Breathing Difficulty	0 Dysmenorrheal
0 Fainting	0 Surgery history	0 Seizure disorder
0 Back pain or injury	0 Knee or ankle weakness	0 Other: _____

Provide information about supportive healthcare needed for each marked item:

Is the participant covered by family medical/hospital/prescription insurance? 0 Yes 0 No

Photocopy of front and back of all health insurance cards must be attached to this form.

This health history is correct and complete as far as I know. I am in good health and able to participate in all camp activities, except as noted by the examining physician and me. I agree to the release of any records necessary for insurance purposes. The first and fourth page of this form may be photocopied for trips out of camp.

Signature of Applicant _____ Date _____

Sign Here

Office Use Only

Office Use Only	
Signature	
Med HX 6 months	
Immuno HX	
Insurance	

Open booklet, there are questions inside!

GENERAL PHYSICAL HISTORY

- 1. Have you ever been hospitalized? 0 Yes 0 No
 Have you ever had surgery? 0 Yes 0 No
- 2. Have you ever passed out during or after exercise? 0 Yes 0 No
 Have you ever been dizzy during or after exercise? 0 Yes 0 No
 Have you ever had chest pain during or after exercise? 0 Yes 0 No
 Do you tire more quickly than your friends during exercise? 0 Yes 0 No
 Have you ever had high blood pressure? 0 Yes 0 No
 Have you ever been told that you had a heart murmur? 0 Yes 0 No
 Have you ever had racing of you heart or skipped heartbeats? 0 Yes 0 No
- 3. Do you have skin problems (itching, rashes, acne)? If so, what type? 0 Yes 0 No
- 4. Have you ever been knocked out or become unconscious? 0 Yes 0 No
 Have you ever had a seizure? 0 Yes 0 No
 Have you ever had a pinched nerve? 0 Yes 0 No
- 5. Have you ever had heat or muscle cramps? 0 Yes 0 No
 Have you ever been dizzy or passed out in the heat? 0 Yes 0 No
- 6. Have you ever sprained, strained, dislocated, fracture, broken or had repeated swelling or other injuries to any of your body parts? If so, where? 0 Yes 0 No
 Do you need assistance or feel discomfort when lifting and carrying 30 pounds at least ten times? 0 Yes 0 No
- 7. Have you had mononucleosis in the past nine months? 0 Yes 0 No
- 8. Do you have a hearing problem? 0 Yes 0 No
 Do you have a vision (sight) problem? 0 Yes 0 No
 Do you wear glasses or contacts or use protective eye wear? If so, what type? 0 Yes 0 No
- 9. Do you smoke and/or use other tobacco products? 0 Yes 0 No
- 10. Do you typically make noise while sleeping (i.e., snore, talk in sleep, etc.)? 0 Yes 0 No
- 11. Do you have any piercings? If so, where? 0 Yes 0 No
 Do you have any tattoos? If so, where? 0 Yes 0 No

NOTE: NEW TATOOS AND PIERCINGS ARE NOT ALLOWED AT CAMP DUE TO THE POSSIBILITY OF INFECTIONS!

- 12. Do you have any problems with your teeth? 0 Yes 0 No
- 13. Have you been in countries other than the USA in the past nine months? Is so, where and when? 0 Yes 0 No
- 14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? 0 Yes 0 No

Explain and/or provide more detail about the General Physical Health questions to which you responded “yes.”

 # _____
 # _____
 # _____
 # _____

MENTAL & EMOTIONAL HEALTH INFORMATION

- A. Have you been diagnosed with Attention Deficit Disorder. 0 Yes 0 No
- B. Have you been diagnosed with Attention Deficit Hyperactivity Disorder? 0 Yes 0 No
- C. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? 0 Yes 0 No
- D. Do you have an eating disorder? Type: 0 Yes 0 No
- E. Do you have a learning disability? Type: 0 Yes 0 No
- F. Do you have an emotional health concern? 0 Yes 0 No
- G. During the past year, have you seen a professional about mental/emotional concerns? 0 Yes 0 No

If “yes” to any question in this section, attach a statement that:

- Describes the concern and your management plan for addressing it while working at camp; and
- Describes the support needed from your work supervisor to compliment your plan.

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Name _____ Date of Birth _____

Record of Immunizations

Immunization	Date Series Completed Or Date of Titer
DPT (Diphtheria, Tetanus, Pertussis)	
Hepatitis A	
Hepatitis B	
Meningitis	
MMR (Mumps, Measles, Rubella)	
Pneumococcal	
Polio	
Tetanus (within 10 years)	
Varicella (Chicken Pox)	
Tuberculin Test Type _____	Year _____
	Results _____

If disease, put D and year.
A TETANUS SHOT GIVEN WITHIN 10
YEARS IS REQUIRED.