

Camp Session attending \_\_\_\_\_

Cabin assignment \_\_\_\_\_

# CAMP TRINITY

P. O. Drawer 380  
Salter Path, NC 28575

## Health History and Examination form for Children, Youth and Adults Attending Camp

**CAMPER'S NAME** \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_  
 Phone: Day (\_\_\_\_) \_\_\_\_\_ Night (\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Vacation address(if applicable) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ Dates: \_\_\_\_\_

### **Second parent or Guardian or Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_  
 (\_\_\_\_) \_\_\_\_\_

If not available in an Emergency,  
 notify: \_\_\_\_\_

Name/relationship \_\_\_\_\_

Family medical/hospital insurance (**please attach copy of insurance card**):

Carrier \_\_\_\_\_ Policy/Group# \_\_\_\_\_

### **Health History:**

(Indicate with approximate dates)

- .....Ear infections
- .....Asthma
- .....Convulsions
- .....Diabetes
- .....Heart defects/disease
- .....Mononucleosis

### **Diseases:**

- .....Measles
- .....German Measles
- .....Chicken Pox
- .....Mumps

**Allergies**(No dates needed):

- .....Hay fever
- .....Ivy Poisoning
- .....Insect bites/stings
- .....Penicillin
- .....Other (specify) \_\_\_\_\_

### **OTHER:**

- Disabilities, chronic or recurring illness: \_\_\_\_\_
- Operations or Serious injuries (Dates): \_\_\_\_\_
- Mental or physical problems: \_\_\_\_\_
- Dietary Modifications: \_\_\_\_\_
- Problems with bed-wetting/comments: \_\_\_\_\_

Has the person presently or previously undergone psychiatric and/or substance abuse treatment of any type? \_\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

### **For Females Only**

- Has this person menstruated? \_\_\_\_\_
- If no, has she been told about it? \_\_\_\_\_
- Is her history normal? \_\_\_\_\_
- Special considerations \_\_\_\_\_

### **Primary Care:**

Name of camper's physician/phone \_\_\_\_\_  
 Name of dentist/phone \_\_\_\_\_

### **Parent comments and suggestions:**

(activities to be encouraged, restricted, special concerns and explanations) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Important!** This box must be completed for a camper to be admitted to camp on registration day.

*This health history is correct to my knowledge and the person described herein has permission to engage in all prescribed camp activities, except as noted. **Authorization for Treatment:** In the event I cannot be reached in an Emergency, I hereby give permission to the Physician, selected by the Camp Director, to secure proper treatment for: transport, hospitalize, and order injection, X-ray, routine tests, anesthesia, or surgery for the person named above. I also give permission to the Camp Nurse to dispense any prescribed medication to the person named above.*

\_\_\_\_\_  
Signature of parent/guardian or adult camper

\_\_\_\_\_  
Date

# MEDICAL EXAMINATION: TO BE COMPLETED BY A LICENSED PHYSICIAN

**PLEASE NOTE:** A health history/examination form must be completed and sent into the camp office **EACH YEAR** by a parent or guardian **30 days** before admission to a camp session.

A physician's examination for some other purpose within the past year is acceptable **if** the information requested on that form is the same as for this request. Examination is necessary in case of illness or accident and to determine fitness to engage in all camp activities

**IMMUNIZATION HISTORY:** (Dates of basic immunizations/most recent booster doses)

|                    |               |   |
|--------------------|---------------|---|
| DTP/DTaP _____     | Booster _____ | MMR _____                               |
| Td/TDAP _____      | Booster _____ | Tuberculin Test _____                   |
| Polio Series _____ | Booster _____ | Varicella (disease) _____ vaccine _____ |
| Hep B Series _____ | Hep A _____   | Menactra _____                          |

**GENERAL APPRAISAL:**

|              |                        |              |
|--------------|------------------------|--------------|
| Height _____ | Weight _____           | BP _____     |
| Eyes _____   | Glasses/contacts _____ | Nose _____   |
| Teeth _____  | Braces _____           | Throat _____ |
| Ears _____   |                        | Heart _____  |
| Speech _____ | Hearing _____          | Lungs _____  |

**RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:**

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Current treatment to be continued at camp \_\_\_\_\_

Specific medications: prescription and OTC, to be administered at camp \_\_\_\_\_

Swimming/Diving \_\_\_\_\_

Strenuous activity (describe) \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Allergies(food, drugs, plant, insect) \_\_\_\_\_

Additional health information \_\_\_\_\_

**Licensed Physician's Signature**

I have examined the person described herein 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.

Signature of Examining Physician\* \_\_\_\_\_ (Please print or type name)

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Telephone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date form completed \_\_\_\_\_ \*By \_\_\_\_\_

\*Initial if completed by nurse or physician's assistant

***A note to parents:*** Please notify the camp nurse **at check - in** if the camper has been exposed to or exhibits any symptoms of a communicable disease during the **three weeks** prior to camp attendance. Do not bring a sick child to camp. We reserve the right to send campers home who are sick on arrival.