ENCAMPMENT HEALTH FORM- PAGE 1

as developed by
American Camping Association, Inc. in consultation with
The American Medical Association and

The American Academy of Pediatrics

INSTRUCTIONS
PLEASE MAIL THIS FORM TO:
NERUSY/HANEFESH – 385 Ward St.
Newton, MA 02459

DEADLINE FOR HEALTH FORM – AUGUST 5, 2015

THIS SIDE TO BE FILLED OUT BY PARENT/GUARDIAN.

Name _____ Birth Date _____ Sex ___ Age ____ Grade ____
Last First Initial
Parent or Guardian _____ Phone (___) _____
Home Address and City _____
Business and/or Day Phone Number _____ Cell phone _____
If not available in an emergency, notify:
Name _____ Relationship _____Phone (___) _____
Full Address _____

FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER _____
Group # _____ Policy # _____

HEALTH HISTORY: ***(Check – giving approximate dates and more specific information/details below.)***

____ ADD with Hyperactivity
____ ADD without Hyperactivity
____ Asthma
____ Athlete's Foot
____ Bleeding Clotting/Disorder
____ Bronchitis
____ Chicken Pox
____ Constipation
____ Convulsions
____ Diabetes
____ Eating Disorders
____ Epilepsy
____ Fainting
____ Frequent Ear Infections
____ Frequent Sore Throats
____ German Measles
____ Heart Defect/Disease
____ Home sickness
____ Hyperactivity
____ Hypertension
____ Kidney Trouble
____ Measles
____ Mononucleosis
____ Panic/Anxiety Attacks
____ Poliomyelitis
____ Psychological Treatment
____ Rheumatic Fever
____ Sinusitis
____ Sleep Walking
____ Stomach Upsets
____ Tuberculosis
____ Hay Fever
____ Poison Ivy, etc.
____ Insect Stings
____ Penicillin
____ Other Drugs (specify below)
____ Substances or Food (specify below)
____ Menstruates (girls)

More details, specific allergies or other diseases (from above) _____
Operations, hospitalizations, serious injuries or illnesses (specify and give date) _____
Disability or chronic or recurring illness (specify) _____
Any specific activities to be restricted by physician's or parent's advice _____
Dietary modifications _____
Current medications or treatments _____
Does your child have a history of/or suffer from depression, anxiety disorder, or anger management problems? Please specify _____
Is your child on any medication for behavior modification? _____Please specify _____
Has your child spent a week away from home previously? _____Has child ever been denied enrollment or sent home early from a camp or weekend? _____ If yes, please explain _____
Describe any circumstance that would result in (a) situation(s) not compatible with group living or any other possibility of problematic behavior _____
Are there any special family situations that we should be aware of?_____
Has your child suffered any unusual psychological/physical trauma? _____
Please list any past illnesses that we should be aware of (both physical and psychological) _____

AUTHORIZATION AND VERIFICATION (This box must be completed)

The above information and health history is correct and completed to the best of my knowledge.

I, the parent or legal guardian, of the applicant, state that he/she is in good normal health, has no abnormal physical or mental handicaps and has my permission to engage in all prescribed camp activities except as noted under restrictions or modifications above or on the reverse side.

My child has no behavioral or emotional problems that would be detrimental or disruptive to others in attendance at camp.

I hereby give my permission to the camp:

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays, routine tests or treatments for my child.
3. In case of medical emergency, accident or a serious health problem where immediate treatment is deemed necessary, I give permission to the physician selected by the Regional Youth Director, Regional Kadima Director or the person designated by the Region to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above. In such case, every effort will be made to contact the parent or guardian of the applicant.

I am aware that this form may be photocopied for use by medical caregivers.

PHYSICAL EXAMINATION- PAGE 2

To be filled out by licensed physician within twelve months prior to camp (MUST be dated after August 18, 2014).
Other medical forms may be accepted (from other camps, summer programs, etc.) as long as the same information is included as requested below.

NAME OF CHILD: _____ DATE OF EXAMINATION: _____

Please record the date (month and year) of basic immunization and most recent booster doses:

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus or	1 2 3	1 2
Tetanus Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____(most recent)		

Health Examination by Licensed Physician
Code: √ -- Satisfactory x – Not Satisfactory (explain)

Hgt. _____ B.P. _____ Urinalysis test done _____ Wt. _____ Hgb. Test done _____
Eyes _____ Extremities _____ Glasses _____ Posture (Spine) _____ Ears _____
Skin _____ Nose _____ Allergies (please specify) _____
Teeth _____ Heart _____ Menstrual history _____ Lungs _____ Abdomen _____
Throat _____ Genitalia _____ Hernia _____ General appraisal _____

I have examined the above camp applicant on (date) _____
In my opinion, the above's condition does _____/does not _____ preclude his/her participation in an active camp program.

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

Current treatment (include current medication): _____
_____
_____

Explanation of any reported loss of consciousness, convulsion, or concussion:_____
_____
Does applicant have epilepsy? Yes ____ No ____ Does applicant have diabetes? Yes _____ No_____

Recommendations and Restrictions While at Camp (diet, medicine, treatment, etc.)_____
_____
Additional Health Information _____

***X* Licensed Physician's Signature** _____*By _____

Please print physician'sfull name: _____

Full Address _____ Phone _____

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