



HEALTH HISTORY AND EXAMINATION

(CONFIDENTIAL INFORMATION)

Camper Name : _____

This form has to be filled out completely and turned in before any consideration will be made for admittance. Please circle "Yes" or "No" for each of the following:

Does the camper have...

- Frequent ear infections? Yes No
- Asthma? Yes No
- Diabetes? Yes No
- Dental Appliances? Yes No

Is the camper allergic to?

- Poison Ivy or Oak? Yes No
- Airborne Agents? Yes No
- Insects Bites or Strings? Yes No
- Animal Fur? Yes No
- Drugs (list below) Yes No

Has the Camper had...

- Family death within 2 years? Yes No
- Friend's death within 2 years? Yes No
- Disciplinary Counseling? Yes No
- Family Counseling? Yes No
- Psychiatric Counseling? Yes No
- Any eating disorders? Yes No

Has the camper experienced...

- Sleep walking? Yes No
- Bed wetting? Yes No
- Nightmares? Yes No
- Alcohol or tobacco use? Yes No
- Mood swings? Yes No

Does the Camper have any learning difficulties? (i.e. ADD, ADHD...) _____

Are the Campers parents divorced? Yes / No Separated Yes / No What year _____

Has the Camper been exposed to suicide attempts among friends or family? Yes / No If Yes, when? _____

Has the Camper discussed or threatened a personal suicide attempt? Yes / No If Yes, when? _____

Is the Camper prone to depression? Yes / No If Yes, about what? _____

Does the Camper have extreme fears? Yes / No If Yes, about what? _____

For female Campers only: Has she been told about menstruation? _____ Has she menstruated? _____ Is her cycle normal? _____

Insurance carrier: _____ Policy/ Group Number: _____

HEALTH EXAMINATION TO BE COMPLETED BY A LICENSED PHYSICIAN:

All information provided pertains to the above named Camper. Weight: _____ Height: _____
Are all immunizations current? _____ Campers last Tetanus shot (date) _____

The Camper has the following recurring illnesses or conditions: _____

The Camper is under my care for the following on-going conditions: _____

Any treatment to be continued at Camp? (List with dosages) _____

Dietary restrictions: _____ Food allergies: _____

Drug allergies: _____ Physical restrictions at Camp? _____

Physician's Signature: _____ Date of Exam: _____

Print Physician's name _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____