



Please return by June 1 to:
CAMP APOLLO
 Post Office Box 34
 Plainview, NY 11803

Completing Grade: _____

This side to be filled out by parent or staff member and checked by physician at time of examination.

Must be an updated yearly physical!

Name _____ Birth Date _____ Sex _____ Age _____
 Last First Initial

Parent/Guardian/Spouse _____

Home Address _____
 Street & Number City State Zip

Home # (_____) _____ Cell # (_____) _____ email _____

If above person is not available in an emergency, please notify:

Name _____ Home(_____) _____ Cell(s)(_____) _____

 Street & Number City State Zip

Name _____ Home(_____) _____ Cell(s)(_____) _____

 Street & Number City State Zip

HEALTH HISTORY: (Check and give approximate dates)

<i>Allergies</i>		<i>Diseases</i>
Ear Infections	Hay Fever	Chicken Pox
Rheumatic Fever	Poison Ivy, etc.	Measles
Seizures/Convulsions	Insect Stings	German Measles
Diabetes	Penicillin	Mumps
Behavior	Other Drugs	Asthma
Headaches	Food (Please specify)	

IMPORTANT: Please notify the camp if this camper or staff member is exposed to any communicable diseases during the three weeks prior to camp attendance.

Operations or Serious Injuries (Dates & Description) _____

Chronic or Recurring Illness _____

Other Diseases or Details of Above _____

Any specific activities to be encouraged or restricted? _____

Suggestions from Parent/Guardian _____



Name _____ Birth Date _____
 Last First

IMMUNIZATION HISTORY – Please send on a separate sheet. This is to be completed by a licensed physician. Required immunizations must be determined locally. This is a record of basic immunizations and most recent booster doses.

MEDICAL EXAMINATION – Examination for some other purpose within the year is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: ✓ = Satisfactory x = Not Satisfactory (explain) O = Not Examined

Date of Physical Exam _____ Height _____ Weight _____ BMI _____ B.P. _____ Pulse _____

Eyes _____ glasses _____ Ears _____ Nose _____ Throat _____ Teeth _____ Heart _____ Lungs _____ Abdomen _____ Hernia _____	Extremities _____ Posture (Spine) _____ Skin _____ Allergy: Please specify _____ General Appraisal _____
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For girls/women:

Has this person menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special considerations: _____

Recommendations and restrictions while in camp:

Special Diet _____

Medicine (name) _____ Is parent sending medicine to camp? _____

Doctor prescription MUST be included for any medication, including over the counter medications.

Swimming, diving _____

Strenuous activity _____

Other _____

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

 Examining Physician M.D. Date Address: _____