CAMP HEALTH EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS

CAMP APOLLO

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

Staff 2018

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)

	Allergies	*Diseases*
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_____

(OVER) →

CAMP APOLLO

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 _____
For girls/women: Has this person menstruated? _____ If so, is her menstrual history normal? _____	If not, has she been told about it? _____ 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.

_____M.D. _____ Address: _____
Examining Physician Date

_____

Revised 7/20/17