CAMP APOLLO
HEALTH HISTORY FORM 2019

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

H-1
STAFF

Completing Grade:_____

TO BE COMPLETED BY STAFF MEMBER/PARENT OF UNDERAGE STAFF

Name_____ **Birth Date**_____ **Sex**_____ **Age**_____
Last First Initial

Mother/Guardian/Spouse_____**Daytime** # (_____)_____

Cell # (_____)_____ **Home #** (_____)_____ **Work # (_____)_____**

Father or Guardian: __________**Daytime (**____)_____

Cell # (_____)_____**Home #** (_____)_____ **Work # (_____)_____**

Mother's Email _____ Father's Email _____

Address: _____
and Street City State Zip

Emergency Contact #1 Name: _____ Emergency Contact # (____)_____

Emergency Contact #1 Name: _____ Emergency Contact # (____)_____

HEALTH HISTORY (TO BE COMPLETED BY STAFF MEMBER/ PARENT OF UNDERAGE STAFF MEMBER)

Allergies to food or medication: _____

Special Dietary Needs _____

Epipen Required? YES or NO

Operations or Serious Injuries _____

Chronic or Recurring Illness or Medical Condition _____

Daily Medications? (**IF YES, MUST FILL OUT H-3 FORM)** _____

As Needed Medications? (**IF YES, MUST FILL OUT H-3 or H-4 FORM)**_____

H-2

STAFF

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CAMP APOLLO

MEDICAL EXAM FORM 2019

Name:_____ **Birth Date:**_____
Last First

Date of Physical Exam:_____

MEDICAL EXAMINATION – An examination for some other purpose within the year is acceptable. It is not necessary to fill this form out if your physician has provided their own physical exam form. The exam must be an updated yearly physical!

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Height:	Eyes:
Weight:	Ears:
Blood Pressure:	Nose & Throat:
Pulse:	Mouth & Teeth:
	Heart:
Urinalysis:	Lungs:
	Abdomen:
	Scoliosis:
ALLERGIES:	

Recommendations and restrictions while in camp:

Dietary Restrictions_____

Under Physicians Care for the following conditions: _____

Current Medications (name)_____ Is parent sending medicine to camp? _____

Doctor prescription MUST be included for any medication, including over the counter medications. See forms H-3 and H-4.

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

_____

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

CAMP APOLLO

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Plainview, NY 11803

H-3

STAFF

REQUEST FOR ADMINISTRATION OF MEDICATION-2019

This form and/or the as needed medication form must be filled out for all medications that are to be administered at camp.

I give permission for my child _____ to receive medication during camp
Camper's name

hours as instructed by my physician.

_____ _____ _____
Signature Relationship Date

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Medication: _____ Purpose: _____

Dosage: _____Route: _____ Time of Day: _____

Special Instructions: _____

Possible Side Effects_____

_____ _____
Signature of Physician Date

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Medication: _____ Purpose: _____

Dosage: _____Route: _____ Time of Day: _____

Special Instructions: _____

Possible Side Effects_____

_____ _____
Signature of Physician Date