

Camp Farley Outdoor Education Center

615 ROUTE 130 MASHPEE, MA 02649 (508) 477-0181 Fax (508) 539-0080 office@campfarley.com

Health History and Examination Form for Children, Youth and Adults Attending Camps

**DO NOT MAIL THIS FORM!!!
YOU SHOULD BRING THIS FORM TO CAMP
ON OPENING DAY!!!**

*Developed and approved by the American Camping Association
with the American Academy of Pediatrics*

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.
(This side to be filled out by parent or guardian of minors or by adult campers/staff members themselves.)

Name of Camper _____ Date of Birth _____ Age _____ Gender M/F _____

Parent/Guardian _____ Day Phone _____ Night Phone _____

Street Address _____ City _____ State _____ Zip _____

Name 2nd Parent/Guardian _____ Day Phone _____ Night Phone _____

Street Address _____ City _____ State _____ Zip _____

Emergency Contact (Someone other than Parents in case parents cannot be reached)

Name _____ Relationship to Camper _____

Day Phone _____ Night Phone _____

Operations or serious injuries (dates) _____

Chronic or recurring illness or condition requiring medical treatment _____

Dietary restrictions _____

Current medications (send with instructions) _____

Other diseases _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp

Current Doctor _____ Phone with Area Code _____

Current Dentist/Orthodontist _____ Phone with Area Code _____

Health History (Check all applicable giving approximate dates)

Health Problems/Diseases (Please provide Dates)

Heart Disease/ Defect _____ Chicken Pox _____

Convulsions _____ Diabetes _____

Bed Wetting _____ Mumps _____

Measles _____ Rheumatic Fever _____

Asthma _____ Kidney Trouble _____

Ear Infection _____ German Measles _____

Allergies

Hay Fever _____ Asthma _____

Poison Ivy, etc. _____ Penicillin _____

Other Drugs _____ Other _____

Foods _____

Insect Bites/Stings _____

Insurance Information Do you carry family medical/hospital insurance? ___ Yes ___ No

Insurance Carrier: _____ Policy Holder: _____ Insurance No. _____

For Females

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is the menstrual history normal? _____ Special Considerations: _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature _____ Date Signed: _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster does.

Immunizations	Year of Basic Immunization	Booster
Diphtheria Pertussis (Whooping Cough) } DPT* or Tetanus	1 2 3	1 2
Tetanus Diphtheria } TD* 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)		
Haemophilus influenza b (HIB)		
Hepatitis B		

THIS SECTION MUST BE COMPLETED FOR OVERNIGHT CAMPERS

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past 24 months. Date examined _____

In my opinion, the above's condition does does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

Is the individual under the care of a physician for any condition or impairment which may affect the individual's activities while attending the camp?

Please explain (include treatment and current medications) _____

Explanation of any reported loss of consciousness, convulsions or concussion _____

Does applicant have epilepsy? _____ Yes _____ No Does applicant have diabetes? _____ Yes _____ No

Recommendations and Restrictions While at Camp

Please list any camp activities from which the individual should be exempted for health reasons _____

Any treatment to be continued at camp _____

Any medication to be administered at camp (please complete medication administration form for each) _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp

Medical Information pertinent to routine care and emergencies _____

I have examined the person herein described and have reviewed her/his health history within the last 24 months. It is my opinion that she/he is physically able to engage in any camp activity except as noted above.

Examining Physician (Please Print): _____ Date Physical Performed: _____

Physician's Signature: _____ Date Signed: _____

Address: _____ Phone Number /Area Code: _____

Date of Form Completion _____ *by _____

*Initial if completed by nurse or physician's assistant