

Health History Form for Children, Youth and Adults Attending Camp Form FM 14

Mail to the address below by _____ (Date)



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.

Name _____ Birthdate _____ Sex _____ Age _____
 Parent or Guardian or Spouse _____
 Home Address _____ Phone _____
 Business Address _____ Phone _____
 Second Parent or Guardian or Emergency Contact _____
 Home Address _____ Phone _____
 Business Address _____ Phone _____
 If not available in an emergency, notify
 Name _____ Phone _____
 Address _____
 Operations or serious injuries (dates) _____
 Chronic or recurring illness or medical condition _____
 Activities encouraged or limited by physician _____
 Dietary restrictions _____
 Current medication (send with instructions) _____
 Other diseases _____

Important — This Box Must be Completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted.
 Signature of parent or guardian or adult camper/staffer _____ Date _____
 Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any record necessary for insurance purposes; and to provide or arrange 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. This completed form may be photocopied for trips out of camp.
 Signature of parent or guardian or adult camper/staffer _____ Date _____
 Witness _____
 I also understand and agree to abide with the restrictions placed on my camp activities.
 Signature of minor or adult camper/staffer _____ Date _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.
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Name _____ Exam. Date _____ Cabin or Tent _____ Year _____

Health History
 (Check. Give approximate dates.)
 _____ Frequent Ear Infections
 _____ Heart Defect/Disease
 _____ Convulsions
 _____ Diabetes
 _____ Bleeding/Clotting Disorders
 _____ Hypertension
 _____ Mononucleosis
Diseases
 _____ Chicken Pox
 _____ Measles
 _____ German Measles
 _____ Mumps
Allergies (Dates not needed)
 _____ Hay Fever
 _____ Ivy Poisoning, etc.
 _____ Insect Stings
 _____ Penicillin
 _____ Other Drugs
 _____ Asthma
 _____ Other (Specify) _____

Name of dentist/orthodontist _____ Phone _____
 Name of family physician _____ Phone _____
 Date of last physical examination _____ Do you carry family medical/hospital insurance? Yes No
 If so, indicate: Carrier _____ Policy or Group # _____
 Carrier Address _____
 Name of person with insurance _____
 Suggestions on health related information for camp personnel _____

For Female
 Has this person menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special Consideration _____
For Camp Use In-camp Health Screening Record
 (Procedures followed should conform with guidelines in the Health Care Procedures approved by the camp physician.)
 1. Observable evidence of illness, injury, disability or communicable disease _____
 2. Current medical treatment required at camp _____
 3. Record of any medications brought to camp _____
 Medications returned to campers _____
 4. Any follow-up recommended by person conducting health screening _____
 5. Date of screening _____ Conducted by _____

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

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus } DPT*	1 2 3	1 2
Tetanus Diphtheria } TD*		
Tetanus		
Oral Polio (Sabin)* TOPV	1 2 3	
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		