

**HEALTH HISTORY & EXAMINATION FORM  
for CHILDREN, YOUTH & ADULTS  
ATTENDING TEATOWN SUMMER CAMP**

Developed by  
American Camping Association, Inc. in cooperation with  
American Academy of Pediatrics

**COMPLETE  
SIGN AND  
RETURN  
BY JUNE 8**

**Mail to the address below:  
TEATOWN LAKE RESERVATION  
1600 Spring Valley Road  
Ossining, NY 10562  
Attn.: Summer Camp  
(914) 762-2912 ext. 111**

**(This side is to be filled in by parents / guardians of minors or by adult campers / staff members themselves.)**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEX \_\_\_\_ AGE \_\_\_\_  
LAST FIRST INITIAL NOW  
 camp session \_\_\_\_\_ group \_\_\_\_\_ am pm full day

PARENT(S)/GUARDIAN/SPOUSE (1) \_\_\_\_\_  
 (2) \_\_\_\_\_

(1) HOME ADDRESS \_\_\_\_\_  
# STREET CITY STATE ZIP  
 HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_  
# STREET CITY STATE ZIP

(2) HOME ADDRESS \_\_\_\_\_  
# STREET CITY STATE ZIP  
 HOME PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_  
# STREET CITY STATE ZIP

**IF PARENTS/GUARDIANS NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
# STREET CITY STATE ZIP

**IMPORTANT: The Following Must Be Completed by Parents for Attendance**

**Your child will not be allowed into camp without the following completed and signed by you.**

**HEALTH HISTORY:**

(CHECK & GIVE APPROX. DATES)

- \_\_\_\_\_ Frequent Ear infections
- \_\_\_\_\_ Heart Defect / Disease
- \_\_\_\_\_ Convulsions
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Bleeding / Clotting Disease
- \_\_\_\_\_ Hypertension
- \_\_\_\_\_ Mononucleosis
- \_\_\_\_\_ Psychiatric Treatment

**DISEASES**

- \_\_\_\_\_ Chicken Pox
- \_\_\_\_\_ Measles
- \_\_\_\_\_ Mumps

**ALLERGIES**

- \_\_\_\_\_ Hay Fever
- \_\_\_\_\_ Ivy Poisoning, Etc.
- \_\_\_\_\_ Insect Stings
- \_\_\_\_\_ Penicillin
- \_\_\_\_\_ Other Drugs
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Other: (specify) \_\_\_\_\_

Has this camper ever required any psychiatric counseling or hospitalization? \_\_\_\_\_ Explain \_\_\_\_\_

Operations or serious Injuries (dates) \_\_\_\_\_

Disabilities or chronic reoccurring illness \_\_\_\_\_

Activities encouraged or limited by physician \_\_\_\_\_

Dietary Modifications \_\_\_\_\_

Current Medications \_\_\_\_\_

Other diseases or details of the above \_\_\_\_\_

Name of Dentist / Orthodontist \_\_\_\_\_ PHONE \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ PHONE \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group: \_\_\_\_\_ Policy: \_\_\_\_\_

Suggestions on health related information for camp personnel:  
 \_\_\_\_\_  
 \_\_\_\_\_

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-ray, routine tests, treatment and necessary transportation for me / 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 my child as named above. The completed forms may be photocopied for trips out of camp.

**SIGNATURE OF PARENT / GUARDIAN :** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

## HEALTH CARE - TO BE COMPLETED BY LICENSED PHYSICIAN

I have examined the above camp applicant within 12 months of the start of camp. Date Examined \_\_\_\_\_

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Current treatment (include current medications) \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Does the applicant have epilepsy? \_\_\_\_\_ Yes \_\_\_\_\_ No Does the applicant have diabetes? \_\_\_\_\_ Yes \_\_\_\_\_ No

Recommendations and Restrictions While at Camp

Any **treatment** to be continued at camp \_\_\_\_\_

Any **medication** to be administered at camp (**specific dosages**) \_\_\_\_\_

Any medically prescribed meal plan or **dietary restrictions** \_\_\_\_\_

Any **allergies** (food, drugs, plants, insects, etc.) \_\_\_\_\_

Additional Health Information \_\_\_\_\_

## 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	1	1
Pertussis (Whooping Cough) DPT	2	2
Tetanus <b>or</b>	3	
Diphtheria	1	
Tetanus <b>or</b>	2	
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red, measles, Rubella)		
Mumps		
Rubella (German Measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Hepatitis B		
Varicella (Chicken Pox)		
Haemophilus influenza (HIB)		

**Licensed Physician's Signature** \_\_\_\_\_

Address \_\_\_\_\_  
Street & Number City State Zip

Phone: \_\_\_\_\_

Date Form Completed \_\_\_\_\_ \*By \_\_\_\_\_

\*Initial if completed by nurse or physician's assistant