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: ___ Vegetarian ___ Gluten Free ___ Kosher ___ Other Details: _____

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 Pertussis (Whooping Cough) DPT Tetanus ***or***	1 2 3	1 2
Diphtheria Tetanus ***or***	1 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