

**CAMP HEALTH EXAMINATION FORM  
FOR CHILDREN, YOUTH AND ADULTS**

*Adapted from the form suggested by the American Camping Association and the American Academy of Pediatrics*

Return by June 1, 2008 to:  
DISCOVERY DAY CAMP  
P. O. BOX 9522  
SILVER SPRING, MD 20916

*This side to be completed by parent or adult camper/staff member and checked with physician at the time of examination. Reverse side to be completed by physician and parent. Please be sure to sign and date the parent's authorization, below.*

NAME \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender (M/F) \_\_\_\_\_ Age \_\_\_\_\_  
Last First Initial

PARENT OR GUARDIAN \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Include Area Code

Home Address \_\_\_\_\_  
Street and Number City State Zip

EMERGENCY CONTACT – if not available in an emergency, notify:

1. \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
or  
2. \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**HEALTH HISTORY**

Has/does the participant:

	Yes	No		Yes	No
1 Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	9 Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
2 Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	10 Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
3 Ever been hospitalized? Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	11 Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
4 Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	12 Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
5 Ever had a head injury? Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	13 Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
6 Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	14 Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7 Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	15 Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8 Ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	16 Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the questions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESTRICTIONS** (The following restrictions apply to this individual.)

Does not eat:  dairy products  nuts / peanuts  other \_\_\_\_\_

*If this individual has an EpiPen/medication related to allergy, please complete ALLERGY and MEDICATION information on reverse side of this form.*

Explain any restrictions to activity, if any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PARENT / EMERGENCY AUTHORIZATIONS**

**Important!** This box must be completed by parent/guardian for all campers and staff under 21 years of age.

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

In the event I cannot be reached in an emergency, I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment for my child as named above.

\_\_\_\_\_  
Parent's Signature Date