



# Health History and Examination Form

Camper's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Term \_\_\_\_\_

Camper's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Parent(s)/Guardian(s) \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Business/Cell Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**If not available in an emergency, please notify:**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Business/Cell Phone \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information:** We must have complete insurance information in order to effectively seek treatment at camp. Please include a copy of your insurance card as well as a copy of your prescription card.

Policy Holder: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Carrier: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Address of Carrier: \_\_\_\_\_ Account #: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_ Phone # of Carrier: \_\_\_\_\_

HEALTH HISTORY:	Explain and/or give dates if applicable	
Frequent Ear Infections _____	Chicken Pox _____	
Mononucleosis _____	Measles _____	
Heart Defect/Disease _____	Mumps _____	
Convulsions _____	Diabetes _____	
Nocturnal enuresis _____	Rubella _____	
Hypertension _____	Asthma _____	
Bleeding/Clotting Disorders _____		

Has this camper ever required any psychiatric counseling or hospitalization? \_\_\_\_\_  
had operations or serious injury? (dates) \_\_\_\_\_

Does this camper have disabilities or recurring illnesses: \_\_\_\_\_

**FOR FEMALES:** Has this camper menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_  
If so, is her menstrual history normal? \_\_\_\_\_ Special considerations: \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please record the date of basic immunizations and most recent booster doses **or attach a copy of shot record.**

Vaccines	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DPT or TD or Td (Tetanus)					
Polio					
Measles					
Mumps					
Rubella					
Haemophilus influenza B (HIB)					
Other					
Tuberculin test given-most recent					

**Health Examination by Licensed Physician:**

Date Examined: \_\_\_\_\_  
(within 12 months of start date of camp)



Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_

The camper is under the care of a physician for the following condition(s) (please include explanation of treatment):

\_\_\_\_\_

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

\_\_\_\_\_

**Recommendation and Restrictions While at Camp:**

Activities to be encouraged or limited by physician's advice: \_\_\_\_\_

\_\_\_\_\_

Dietary modifications: \_\_\_\_\_

List any allergies (food, drugs, plants & insects, etc.) and please describe reaction: \_\_\_\_\_

\_\_\_\_\_

Additional Health Information for Camp Balcones Springs Staff: \_\_\_\_\_

\_\_\_\_\_

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

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

Examining Physician's Name (Print) \_\_\_\_\_

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp:

1. To provide ongoing health care; and, 2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above. Furthermore, in the event I cannot be reached in an emergency, I hereby give permission to the medical professional selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

\* **SIGNATURE** of Parent or Guardian \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of minor: \_\_\_\_\_ Date: \_\_\_\_\_

This section is to be filled out ONLY IF your child will be bringing medication to camp.

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication	Purpose for Medication	Dose	Frequency of doses	Duration
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is the medication in the bottle the same as what is printed on the label? \_\_\_\_\_

Are the instructions on the label the same as above? \_\_\_\_\_

**\*\*Please make sure you have brought enough medication to last the entire duration of your campers stay.\*\***

Please give any additional information including any side effects, how long the camper has been taking this medication, etc:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_