

**HEALTH EXAMINATION FORM
CAMP GLEN ARDEN
POST OFFICE BOX 7
TUXEDO, NC 28784
(828) 692-8362**

THIS SIDE TO BE COMPLETED BY PARENTS

CAMPER LAST NAME: _____ FIRST NAME _____ MI _____

DOB _____ SEX _____

Home Address _____

Social Security Number _____ Home Phone _____

Parent/Guardian _____ Home Phone _____ Cell Phone _____

Business Phone _____ Fax Number _____

IF PARENT/GUARDIAN NOT AVAILABLE IN CASE OF EMERGENCY, NOTIFY:

1. Name _____ Home Phone _____ Business Phone _____ Cell Phone _____
Address _____

2. Name _____ Home Phone _____ Business Phone _____ Cell Phone _____
Address _____

Health History:

Serious Medical Conditions _____

Any Restricted Activity _____

Have menstrual periods started _____ Any special considerations _____

Other health history you feel is important _____

IMPORTANT: Please notify camp if exposure to infectious disease or lice outbreak occurs during 3 weeks prior to camp.
If camper wears glasses, please send an extra pair as well as prescription.
If camper has braces, send a good supply of all materials. An extra retainer is recommended.

REQUIRED INSURANCE INFORMATION: Please send a photocopy of insurance card, front and back.

Name of Policy Holder _____ Relationship to camper _____

Insured's birthday _____

Insurance Company Name _____ Policy Number _____

Address for claims _____ Phone Number _____

AUTHORIZATION: This information is correct to the best of my knowledge and the above named individual has permission to engage in all camp activities, except as noted by me or the examining health care provider. I give permission for camp to secure medical treatment for my child. I accept responsibility for any medical expense involved.

Parent/Guardian

Date

THIS SIDE TO BE COMPLETED BY HEALTH CARE PROVIDER

CAMPER NAME: _____

Immunizations: Give date of completion of series or last booster

DPT _____ MMR _____
Polio _____ Hepatitis B _____
HIB _____ Tetanus _____
Vericella _____ or Chicken Pox _____
TB test _____ (Neg/Pos) If positive, treatment _____

Medical/Surgical History: Give dates as appropriate

Problems with anesthesia? _____
Allergies: Drugs _____ Insects _____
Foods _____ Other _____
Serious Injuries _____
Surgery _____
Restricted Activity _____
Seizures _____ Asthma _____ Diabetes _____
Bed wetting _____ Other Chronic Illness/Health Problem _____

Has camper ever been under care of a psychiatrist or psychologist? _____, or ever had an eating disorder? _____
If yes, please provide camp with appropriate details. _____

Current prescription drugs camper is taking (Name of drug and administration instructions)

Special Diet: _____

Physical Exam: Examination within 6 months before arrival at camp is acceptable.

Height _____ Weight _____ BP _____ Vision R _____ L _____
Urinalysis (If done) _____ Hct (If done) _____
General Appraisal _____
HEENT _____
Skin/Hair/Nails _____
Heart _____
Lungs _____
Abdomen _____
Extremities _____
Spine _____
Other information to facilitate health care while at camp _____

I have examined this person and have reviewed his/her health history. It is my opinion that she is physically able to engage in camp activities except as noted above.

Physician's Signature _____ Date _____

Address _____ Phone _____