



**CAMP HEALTH EXAMINATION FORM  
for CHILDREN, YOUTH and ADULTS**

**RETURN TO:  
ARROWHEAD DAY CAMP  
240 Dutton Mill Road  
West Chester, Pa 19380-6601**

**RETURN BY 6/10  
Or Fax (Both sides)  
(610) 695-8118**

*This side to be filled in by parent and checked by physician at time of examination.*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First Initial

Parent or Guardian (or Spouse) \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_  
Street & number City State Zip Code

Mother's Work Phone# \_\_\_\_\_ Father's Work Phone # \_\_\_\_\_

Cell Phone# \_\_\_\_\_ Beeper # \_\_\_\_\_

If not available in an emergency, please notify:

1. \_\_\_\_\_ Phone \_\_\_\_\_  
Name/Relationship Area Code & Number  
Street & number City State Zip Code

or 2. \_\_\_\_\_ Phone \_\_\_\_\_  
Name/Relationship Area Code & Number  
Street & number City State Zip Code

Family Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Company Policy No. \_\_\_\_\_

**HEALTH HISTORY:**

Child had physician's examination in last  Year  2 Years  3 Years  More  Never

I consider the child's health  Excellent  Above Average  Below Average  Average  Poor

Sunburns easily  Yes  No

Behavioral/Emotional problems we need to be aware of \_\_\_\_\_

Chronic or Recurring illness \_\_\_\_\_

Any specific activities to be restricted? \_\_\_\_\_

**Important:** Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp.

**PARENT'S AUTHORIZATION**

This health history is correct so far as I know, and the person herein described has permission to engage in all pre-scribed activities, except as noted by me and the examining physician.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child as named above.

I hereby give the camp permission to administer children's dosage of over the counter medication (Tylenol, Tums, Benadryl) as deemed necessary by the nursing staff. **Please check :**  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_ (over)

**THIS SECTION TO BE FILLED IN BY CAMPER' S PHYSICIAN**

**IMMUNIZATION HISTORY**

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DPT Series \_\_\_\_\_ booster \_\_\_\_\_ Tetanus Booster \_\_\_\_\_  
Polio \_\_\_\_\_ booster \_\_\_\_\_ Tuberculin Test \_\_\_\_\_  
MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_ Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
Other \_\_\_\_\_

**MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN**

This examination should be performed within six months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

**Code:** ✓ - Satisfactory      X - Not Satisfactory (explain)      O - Not Examined

Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Throat \_\_\_\_\_ Glasses \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_  
Extremities \_\_\_\_\_ Heart \_\_\_\_\_ Abdomen \_\_\_\_\_ Skin \_\_\_\_\_ Posture (Spine) \_\_\_\_\_ Lungs \_\_\_\_\_  
Hernia \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Hgb. Test \_\_\_\_\_ Urinalysis \_\_\_\_\_ B.P. \_\_\_\_\_

**Allergy (s): Please specify:** \_\_\_\_\_

**MEDICATIONS BEING TAKEN**

Please list ALL medications (Prescription, Non-Prescription and Emergency). Bring enough medication to last the entire time at camp. Keep it in the original package or bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications.

This person takes medications as follows: (include Insulin, Glucagon, Epipen, etc.)

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_  
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Reason for taking \_\_\_\_\_  
Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

**\*Recommendations and restrictions while in camp.**

Special Diet \_\_\_\_\_  
\*Swimming/Diving \_\_\_\_\_  
\*Strenuous Activity/Heat Tolerance \_\_\_\_\_  
Other \_\_\_\_\_

General Appraisal: \_\_\_\_\_

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

\_\_\_\_\_  
Examining Physician

Telephone \_\_\_\_\_ Address \_\_\_\_\_

Date \_\_\_\_\_