

Camp Health Examination Form Part I

Name: _____ Birthdate: _____ Sex: M/F Age: _____ (circle one: Staff/Camper)
Address: _____

Mother/Guardian: _____ Email address _____
Home Phone _____ Work Phone _____ Cell Phone _____

Father/Guardian: _____ Email address _____
Home Phone _____ Work Phone _____ Cell Phone _____

Persons to contact if parent/guardian is unavailable:

1) Name _____ Relation to child _____ Home Phone _____
Email address _____ Cell Phone _____

2) Name _____ Relation to child _____ Home Phone _____
Email address _____ Cell Phone _____

Health History explain yes answers and give dates

Has/Does the camper/staff: _____ Yes/No **ALLERGIES** _____

- 1. Had any recent injury, illness or infectious diseases _____
- 2. Have a chronic or recurring illness/condition _____
- 3. Ever been hospitalized _____
- 4. Ever had surgery _____
- 5. Have frequent headaches _____
- 6. Ever had a head injury _____
- 7. Ever have loss of consciousness _____
- 8. Wear glasses, contacts or protective eye wear _____
- 9. Ever had frequent ear infections _____
- 10. Ever had seizures _____
- 11. Ever have dizziness during exercise _____
- 12. Ever diagnosed with a heart murmur _____
- 13. Ever diagnosed with heart arrhythmias _____
- 14. Ever had back problems _____
- 15. Ever had joint problems/injuries _____
- 16. Have an orthodontic appliance _____
- 17. Wear braces _____
- 18. Have any skin problems/ailments _____
- 19. Have diabetes _____
- 20. Have asthma _____
- 21. Had mononucleosis in past 12 months _____
- 22. Had problems with diarrhea/constipation _____
- 23. Have problems sleepwalking _____
- 24. Had lice infestation (when) _____
- 25. Have an abnormal menstrual history (If female) _____
- 26. Have ADD/ADHD _____
- 27. Have OCD/ODD _____
- 28. Ever have Lymes disease (when) _____

PLEASE ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD

This health history is correct and complete as far as I know. I hereby give permission for Berkshire Hills Emanuel Camp's Medical staff to provide routine health care, administer prescribed and over the counter medications, and seek emergency and/or surgical treatment for said camper/staff. All bills for physician's care, dental care, hospital visits, laboratory tests, x-rays and prescription medication will be sent directly to the family for submission to its insurance plan.

Signature of Parent or Guardian _____ Date _____

2008 **Berkshire Hills-Emanuel Camps**
Camp Health Examination Form Part II
TO BE COMPLETED BY HEALTH CARE PROVIDER

Required Form

Name: _____ Age: _____ Weight: _____ Height: _____

ALLERGIES: (If none Please document – NONE)

PHYSICAL EXAMINATION

BP _____ HR _____ RR _____ Vision OD 20/ _____ OS 20/ _____

Head _____ Ears _____
Eyes _____ Nose _____
Throat _____ Scalp _____
Muscular/Skeletal _____ Respiratory _____
Cardiovascular _____ Neurological _____
Liver _____ Spleen _____
Gastrointestinal _____ Gastrourinary _____
Genitalia _____
(For Females) Has menstruation begun/ has menstruation normal _____
Other illnesses or surgeries _____

Please briefly describe any pertinent positives: _____

Immunization History

Polio: #1 _____ #2 _____ #3 _____ #4 _____ **DTaP:** #1 _____ #2 _____ #3 _____ #5 _____ **MMR:** #1 _____ #2 _____

HBV: #1 _____ #2 _____ #3 _____ **HiB:** _____ **HPV:** #1 _____ #2 _____ #3 _____

Varicella: _____ **Meningococcal vaccine:** _____

Had camper/staff have: Measles _____ Chicken Pox _____ German Measles _____ Mumps _____
Hepatitis A _____ Hepatitis B _____ Hepatitis C _____

TB Mantoux Test (PPD): Date of last test _____ Results _____

Limitations to activities: Swimming _____ Diving _____ Hiking _____ Athletics _____ Other _____

Please explain above: _____

I certify that I have on this date examined the above named camper/staff and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper/staff to participate in physically strenuous activities. It is my opinion that this person is physically able to engage in all camp activities

Licensed Physician's Signature _____
Licensed Independent Practitioner Signature(if examined by other than an MD) _____

Address _____ License# _____

Telephone Number _____ Date _____