Health History and Examination Form for Children, Youth and Adults Attending Camp

Mail To the Address below by _____Date

Wilbert E. Burgie Cadet Corps, Inc.
P.O. Box 328
Bronx, NY 10467

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.
(*This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.)*

Name_____ Birth date_____ Sex_____ Age_____
Last First Initial

Parent or Guardian (or Spouse)_____

Home Address_____ Phone_____
Street & Number City State Zip Area/Number

Second Parent or Guardian or Emergency Contact_____

Home Address_____ Phone_____
Street & Number City State Zip Area/Number

Business Address_____ Phone_____
Street & Number City State Zip Area/Number

If not available in an emergency, notify
Name_____

Address_____ Phone_____
Street & Number City State Zip Area/Number

Health History
(Check, Give appropriate dates.)
_____ Frequent Ear Infection
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis

Diseases
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (Dates not needed)
_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other (Specify)
_____
_____

Operations or serious injuries (dates)_____
_____
Chronic or recurring illness or medical condition_____
_____
Dietary restrictions_____
Current medications (send with instructions)_____
_____
Other diseases_____
Name of dentist/orthodontist_____ Phone_____
Name of family physician_____ Phone_____
Do you carry family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate: Carrier_____ Policy or Group #_____
Carrier Address_____
Suggestions on health related information for camper personnel_____
_____
_____

For Female
Has this person menstruated?____ If not, has she been told about it?_____
If so, is her menstrual history normal? _____ Special Consideration_____

Important – This Box Must be Completed for Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes: and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.
Signature of parent or guardian or adult camper/staffer_____
Witness _____ Date_____
I also understand and agree to abide with the restrictions placed on my camp activities.
Signature of minor or adult camper/staffer_____ Date_____

Name_____ Date Examined_____ Cabin or Tent_____ Year_____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) } DPT* Tetanus or	1 2 3	1 2
Tetanus } DPT* Diphtheria or		
Tetanus		
Oral Polio (Sabin) * TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given_____(most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. Date Examined_____

In my opinion, the above conditions ☐ does ☐ does not preclude his/her participation in an active camp program.

Height_____ Weight_____ Blood Pressure_____

The applicant is under the care of a physician for the following condition(s)

_____

Current treatment (include current medications)_____

_____

Explanation of any reported loss of consciousness, convulsion, or concussion_____

_____

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp_____

Any medication to be administered at camp (specific dosages)_____

Any medically prescribed meals plan or dietary restrictions_____

_____

Any Allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited_____

Additional Health Information_____

Licensed Physician's Signature_____

Address_____ Phone_____

Street & Number City State Zip Area/Number

Date of Form Completion_____ By_____

Name_____ Date Examined_____ Cabin or Tent_____ Year_____