



Camp La Junta Health Examination Form

First Term	<input type="radio"/>
1A	<input type="radio"/>
1B	<input type="radio"/>
Second Term	<input type="radio"/>
2A	<input type="radio"/>
2B	<input type="radio"/>
Please indicate your term.	

Camper's Name _____ Birth Date _____
Last First

Parent's Name(s) _____ Camper's Age: _____

Address _____
House no. & Street City State Zip

In an Emergency, Notify _____ Phone _____

Please comment on the frequency of the following conditions for your son. (Please list dates below)

Colds _____	Fevers _____	Seizures _____
Sore Throats _____	Bed Wetting _____	Asthma _____
Sinusitis _____	Headaches _____	Bleeding/Clotting Disorders _____
Ear Infections _____	Stomach/Digestive Problems _____	Diabetes _____
Bronchitis _____	Athletes Foot _____	Heart Defect/Disease _____

Please list any childhood diseases he's had (measles, mumps, chicken pox) and dates: _____

IMPORTANT: The Camp must be notified if this camper is exposed to any major communicable disease -- eg. Chicken Pox, head lice, meningitis, hepatitis -- during the three weeks prior to camp attendance to determine if a delayed arrival is necessary.

Please list any medications (with dosages) that your son will be bringing to camp _____

Allergies (list) _____
 Serious Poison Ivy, Oak or Sumac Reactions. _____
 Allergic Reactions: Stings _____ Penicillin _____ Other Drugs : _____
 Operations, Serious Injuries (give dates) _____
 Disabilities, chronic or recurring illness _____
 Nervous Disorders _____ Learning Disabilities _____
 Details of any of the above information _____
 Any specific activities to be restricted? _____

MEDICAL EXPENSES/INSURANCE

In addition to your health insurance policy, campers are covered under a camp accident policy which has 0 deductible and \$2500 accident coverage. Illness-related bills and accident bills exceeding this coverage will be the parents'/guardians' responsibility. Please provide the following information (or attach a copy of your insurance card - front and back):

Insurance Provider: _____ Policy Holder's Name: _____
 Insurance address: _____ Insurance phone: _____
 Policy/Group No. : _____

Important Release - Must be Completed before Attendance

Parent's Authorization: This health history is correct so far as I know, and my son is physically able and has permission to engage in all prescribed camp activities except: _____
 If medical treatment is necessary, I hereby give permission to the camp director to secure proper medical treatment, which may include, but not be limited to medication, medical, dental and/or orthodontic care, hospitalization, surgery, ordering of injection, and/or anesthesia, for my son.

Signature: _____ Date: _____
Parent

IMMUNIZATION HISTORY:

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

DTaP Series & boosters _____ Tetanus Booster _____
 Polio OPV/IPV & boosters _____ Chickenpox (Varicella) _____
 Measles, Mumps Rubella MMR _____ Hepatitis B _____
 Hib series _____ Other _____
 Any major illnesses in the past year: _____

Campers must have had a complete physical in the past year and sign below stating such (new campers send copy of exam), OR must have a Physician complete the form below.

I hereby confirm that my son has successfully passed a doctor's physical examination in the past year. Unless stated on the front of this form, he is healthy to participate in all camp activities.

Signature: _____ Date: _____
 Parent

MEDICAL EXAMINATION: to be completed by licensed physician.

This exam 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: *S - Satisfactory* *X - Not Satisfactory* **O - Not Examined**

Hgt. _____ Wt. _____ B.P. _____

Eyes _____
 glasses _____
 Ears _____
 Nose _____
 Throat _____
 Teeth _____
 Heart _____
 Abdomen _____
 Hernia _____

Extremities _____
 Posture (spine) _____
 Skin _____
 Allergy: Please specify _____

 General Appraisal: _____

Recommendations or restrictions while in camp:

Diet Modifications _____
 Current Medication(s) (specify) _____ Is parent sending it? _____
 Swimming, diving restrictions _____
 Strenuous Activity _____
 Other _____

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

_____ M.D.
 Examining Physician

Telephone no. _____
 Area code & No.

Address _____

Date _____

City

State

Zip