CAMP HEALTH HISTORY AND EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS

Developed by American Camping Association, Inc. in conjunction with
The American Medical Association and the American Academy of Pediatrics

*** YOU MUST SUBMIT A DOCTOR'S MEDICAL FORM ALONG WITH THIS FORM FOR IMMUNIZATIONS. PLEASE ALSO SEND IN EPI PENS FOR ALLERGIES AND INHALERS FOR ASTHMA, ALONG WITH DOCTOR'S INSTRUCTIONS.**

RETURN TO:
Long Island Voyager's Day Camp
P.O. Box 1111
West Babylon, NY 11704

This must be filled in by parents/guardians of minors or by adult camper/staff members themselves.

Name:_____ Birth Date:_____ Sex:_____ Age: _____
Last First Initial

Parent or Guardian (or spouse):_____ Phone: _____
Area/Number

Home address:_____
Street & Number City State Zip

Business 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:_____ Phone: _____
Area/Number

Address: _____
Street & Number City State Zip

Health History (Check giving approximate dates)

Frequent Ear Infections		Mononucleosis		Allergies	
Heart Defect/Disease				Hay Fever	
Convulsions		Chicken Pox		Ivy, Poisoning, Etc.	
Diabetes		Measles		Insect Stings	
Bleeding/Clotting Disorders		German Measles		Penicillin	
Hypertension		Mumps		Other Drugs	
				Asthma	

Operations or serious injuries (dates): _____

Disability or chronic or recurring illness:_____

Any specific activities to be encouraged or limited by physician's advice:_____

Dietary modifications:_____

Current medication (send with instructions):_____

Other diseases or details of above:_____

Name of dentist/orthodontist:_____ Phone: _____
Area/Number

Name of family physician: _____ Phone: _____
Area/Number

Date of last physical examination_____

Do you carry family medical/hospital insurance?_____ If so indicate:

Carrier: _____ Policy or group #: _____

Suggestions or health related information for camp 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.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me/or my child and 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 to order injection and or anesthesia and/or surgery for me/my child as issued above. This form may be photocopied for use 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: _____

** If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.*

This camp is licensed by the Nassau County Department of Health