

CAMPERS HEALTH EXAMINATION FORM FOR BOYS & GIRLS

DEVELOPED AND APPROVED BY AMERICAN CAMP ASSOCIATION & AMERICAN
ACADEMY OF PEDIATRICS

REQUIRED BY PA STATE LAW
WILLOW GROVE SUMMER DAY CAMP, INC.
3400 DAVISVILLE ROAD
P.O. BOX 398
WILLOW GROVE, PA 19090-0398
PHONE: (215) 659-4393
FAX: (215) 659-5187

(This side to be filled in by parent and checked with physician at time of examination)

Name _____ Sex _____ Birth Date _____ Age _____
Mother/Guardian _____ (C) _____ (W) _____
Father/Guardian _____ (C) _____ (W) _____

Emergency contact (other than parent) _____ (relationship) _____
(H) _____ (C) _____ (W) _____

Health History:

Allergic Reactions: Bee Sting _____ if yes, please state reaction _____
Food _____ if yes, please state reaction _____
Other _____ if yes, please state reaction _____

Specific activities to be restricted. _____

Does this child have any physical or developmental problems? _____

If yes, describe _____

Please list any medications your child takes daily: _____

Will you be leaving any medications for the nurse to administer during the camp season?
State: _____

May this child take Tylenol and/or Motrin if needed? _____

IMPORTANT: Please notify the camp if this child is exposed to any communicable disease during the three weeks prior to camp attendance.

IN CASE OF EMERGENCY I understand every effort will be made to contact parents or guardian of campers. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

Signature of parent _____ Date _____

Parent: Complete this side and sign above.

Physician: Complete reverse side.

This form must be returned to camp office by June 1st. to complete enrollment.

PHYSICAL EXAMINATION

To be filled out by licensed physician.

(Within three months prior to camper's arrival at camp to permit correction of any remedial defects)

Code: Satisfactory
Not Satisfactory (Explain)

Hgt. _____ B.P. _____ Urinalysis test done: _____
Wt. _____ Hgb. Test done: _____
Eyes _____ Glasses _____
Extremities _____ Posture (spine) _____
Ears _____ Skin _____
Nose _____ Allergy – Please specify _____
Throat _____ Emotional Stability __ Much __ Some __ Little __ None
Teeth _____ Maturity __ Much __ Some __ Little __ None
Heart _____ Any Personal Problems __ Much __ Some __ Little __ None
Lungs _____ Any Behavior Problems: Explain _____
Abdomen _____ Any Learning Problems: Explain _____
Genitalia _____ Menstrual History (for girls only) _____
Hernia _____ General Appraisal _____

Recommendations and restrictions (diet, medicine, swimming, diving, etc.) _____

Significant Medical Concerns: _____

D.P.T Series _____	Booster _____	date _____	
Tetanus Booster _____		date _____	
Polio Series _____	Booster _____	date _____	
Small Pox _____		date _____	
Typhoid Series _____	Booster _____	date _____	(if required by camp)
Measels _____	Booster _____	date _____	
Mumps _____	Booster _____	date _____	
Rubella _____	Booster _____	date _____	
Haemphilis (Hib) _____	Booster _____	date _____	

Signature Examining Physician: _____

Address: _____

Telephone: _____

Date: _____