In consultation with The American Medical Association and
The American Academy of Pediatrics

SANFORD DAY CAMP

This side to be filled in by parent of adult camper and checked with physician at time of examination.

Name ________________________________ Birth Date ___________ Sex____ Age___
Last First Initial

Parent or Guardian (or Spouse) ________________________________ Home Phone _________
Name Work Phone __________

Home Address ____________________________________________________________
Number and Street City State Zip

Other Parent or Guardian ______________________________________ Home Phone ________
Name Work Phone ________

If not available in an emergency, notify:

1. ________________________________________________________ Phone __________
Name

________________________________________________________________________
Street & Number City State Zip

2. ________________________________________________________ Phone _________
Name

________________________________________________________________________
Street & Number City State Zip

HEALTH HISTORY: (CHECK – GIVING APPROXIMATE DATES)

ALLERGIES

| | | | | | |
|---|---|---|---|---|---|
| EAR INFECTION | ________ | HAY FEVER | _______ | CHICKEN POX | _____ |
| HEART RELATED | ________ | PLANT | ______ | MEASLES | _____ |
| CONVULSIONS | ________ | INSECT STINGS | ______ | GERMAN MEASLES | _____ |
| DIABETES | ________ | FOOD | ______ | MUMPS | ______ |
| BEHAVIOR | ________ | DRUGS | ______ | ASTHMA | ______ |

Operations or Serious Injuries (Dates ) ____________________________________________
Chronic or Recurring Illness ______________________________________________________

Other Diseases or Details of Above

______________________________________________________________________________

__________________________

Any specific activities to be encouraged? __________________________________________
Any specific activities to be restricted? ___________________________________________

IMPORTANT: Please notify the camp if this camper is exposed to any communicable diseases During the three weeks prior to camp attendance.

Parent's Authorization - This health history is correct so far as I know, and the person herein described has Permission to engage in all camp activities on or off premises, except as noted by me And the examining physician.
In the event I cannot be reached in an emergency, I hereby give permission to the Camp And medical authorities to transport and medically treat my child.

Signature: ________________________________________

IMMUNIZATION HISTORY:
Required immunizations must be determined locally. This is a record of dates of basic immunizations and mist recent booster doses.

DIP Series ________________________ Booster _____________ Tetanus Booster _____________
Polio QPV (Sabin) ________________ Booster _____________ Typhoid ___________________
Measles Vaccine (live) __________________________________ Tuberculin _________________
German Measles (Rubella) ________________________________ Mumps Vaccine ____________
Smallpox _______________________________________________ Other ____________________
Other state or municipal examinations required (if any) ____________________________________

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MEDICAL EXAMINATION – To be filled out by a licensed physician.
This examination should be performed within 12 months of arrival at camp. Examination for some other purpose wthin this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

CODE: S – Satisfactory X – Not Satisfactory (explain) O – Not examined

Hgt. __________ Wt. ___________ B. P. _____________ Hgb. Test ______ Urine _________

Eyes___________________________________
Glasses ________________________________
Ears ___________________________________
Nose ___________________________________
Throat _________________________________
Teeth __________________________________
Heart __________________________________
Lungs __________________________________
Abdomen _______________________________
Hernia _________________________________

Extremities
Posture (spine)
Skin
Allergy: Please specify __________________
________________________________________
________________________________________
General Appraisal: ________________________
________________________________________
________________________________________
________________________________________

(For Girls and Women)
Has this person menstruated? ___________ If not, has she been told about it? ____________________
If so, is her menstrual history normal? __________________ Special considerations: ______________

Recommendations and restrictions while in camp.
Special Diet ________________________________________________________________________
Special Medicine (name it) ___________________ Is parent sending it? ________________________
Swimming, diving ____________________________________________________________________
Strenuous activity ____________________________________________________________________
Other _______________________________________________________________________________
I have examined the person herein described and have reviewed his/her health history. It is my opinion That he/she is physically able to engage in camp activities, except as noted above.

__________________________________M.D.
Examining Physician

Telephone: __________________________
Area Code and Number

Address: _________________________________
Street and Number

Date:_________________________________

________________________________________
City State Zip