

IMPORTANT: A health history revised within the past 12 months by a parent or guardian and a physical examination conducted within the past 36 months are required for each youth camper and adult under 40 years old. Adults over 40 years old must show evidence of physical examination within the past 12 months. A parent or guardian must attest to the validity of the health history and physical examination for those under 18 years old.

SECTION A

Approved by the State of Connecticut
YOUTH CAMP HEALTH EXAMINATION RECORD

For Camp Use
Date Arr. _____
Date Dep. _____

Adult _____ Youth _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

Name _____ (last) _____ (first) _____ Sex _____ Age _____ Birth Date _____

Address _____ (street) _____ (town) _____ (state) _____ (ZIP) _____ Telephone (H) _____

Telephone (B) _____

In Emergency, Notify _____ Relationship _____

Address _____ Telephone _____

HEALTH HISTORY (check)

Chicken Pox _____ Measles _____
German Measles _____ Mumps _____
Whooping Cough _____ Other _____

ALLERGIES

Hay Fever _____ Insect Sting _____
Asthma _____ Drugs (specify) _____
Ivy, Oak, etc. _____ Foods (specify) _____

CHRONIC/RECURRING ILLNESS

Earaches _____ Throat Problems _____
Sinus _____ Infections _____
*Heart _____ Stomach _____
*Epilepsy _____ Rheumatic Fever _____
*Diabetes _____ Menstrual Problems _____
*Seizures _____ *Any asterisked illness please explain in detail

Details of Above _____

Medications being taken (name and explain) _____

Operations, Injuries, Special Restrictions (explain, give dates) _____

IMMUNIZATIONS DATE BOOSTER

Diphtheria _____
Tetanus _____
Pertussis _____
Polio _____
Measles _____
Mumps _____
Rubella _____
Other _____

PARENT OF GUARDIAN AUTHORIZATION (REQUIRED FOR ALL PERSONS UNDER AGE 18)

This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. In case of accident, injury, or illness while at camp, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my son.

Signature _____ Date _____

SECTION B If school physical is to be used, please fill in Section A and attach to school form

PHYSICAL EXAMINATION: TO BE COMPLETED BY A LICENSED PHYSICIAN Code: (0) Not Examined (1) Satisfactory (2) Not Satisfactory

Height _____ Weight _____ B.P. _____ Skin _____ Nose _____

Eyes _____ Glasses _____ Contacts _____ Required _____ Condition _____

Ears _____ Hearing Right _____ Left _____

Throat _____ Teeth _____ Heart _____ Lungs _____ Skeletal _____

Abdomen _____ Genitalia _____ Hernia _____ Extremities _____

Tests: Urinalysis Glucose? _____ Albumin? _____ Tuberculin Testing (Type) _____

If Indicated, Blood Count _____

Restrictions, Limitations (including diet) _____

Medications _____

Recommendations _____

The above-named person is in satisfactory condition and may engage in all camp activities except as noted:

Date _____ Examining Physician _____

Telephone _____ Print Physician's Name _____

State Licensed in _____ LIC# _____ Address _____

MEDICAL EVALUATION

REVIEW FOR CAMP OR SPECIAL ACTIVITY

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	INITIAL

INTERVAL RECORD

(CAMP, JAMBOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.)	BY:

In the event my son must leave camp before scheduled,
I authorize the following persons to pick him up:

Name(s) Telephone(s)

Agency other than original: Please accept PERSONAL HEALTH AND MEDICAL RECORD as evidence either of examination or that appropriate health review and memorandum was made by physician as of date signed. Other details are available from original agency or physician. Please return record to applicant after short-term activity. Copy may be made for applicant's file, if needed.