# Health History and Examination Form
## Camp Academia Inc.

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Please complete and 1) Email to the addresses above 2) Send by FAX transmission or
Mail to: Camp Academia, Inc. Post Office Box 2954, LaGrange, GA 30241

Full Name of Camper_____ Birthday _____Sex_____ Age_____

School _____ Grade _____ Teacher_____

Parent(s) or Guardian_____ Email _____

Home Address_____City_____

State_____ Zip_____ Home Phone (_____) _____Mobile (___)_____

Place of Employment Name & Address _____

City_____ State_____ Zip_____ Phone _____

Second Parent / Guardian or Emergency Contact_____ Relationship_____

Address_____ Email _____

Phone (_____) _____ Business Ph:_____Mobile PH: _____

Emergency Contact _____ Phone (_____) _____

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_____

Has your camper been tested for learning disabilities, language processing, dyslexia etc.? _____ If yes, when? _____ Have you provided the staff with a copy of this testing? _____ was your camper diagnosed with a learning disability? _____
Does his/her disability affect reading_____ spelling_____ handwriting_____ written expression_____?
Verbal expression_____ coordination_____ copying from the board or books_____

Operations or serious injuries_____Dates_____

Chronic or recurring illness_____

Activities encouraged or limited by physician

_____

Dietary
modifications_____

Current Medications (*send with instructions*)

_____

Family physician_____ Phone (_____) _____

Date of last physical examination_____ Do you carry family medical/hospital insurance? ___yes ___ no

Carrier Name _____ Policy # _____

Expiration_____ Phone Number _____ Primary Person _____

For Female: Has this person menstruated? ____yes ____no, if not has she been told about it? ___ Yes ___ no

If yes, is her menstrual cycle regular? ___ yes ___ no Special Considerations_____

Health History: check all that apply and give approximate dates.

| | |
|---|---|
| _____poison ivy (severe reaction requiring M.D.)<br>_____allergies to prescription drugs<br>_____frequent ear infections<br>_____skin rash or other problems | _____behavior disorders<br>_____enuresis<br>_____encopresis<br>_____ Oppositional Defiant Disorder |
| _____heart defects/disease | _____chicken pox |
| _____convulsions | _____measles |
| _____diabetes | _____German measles |
| _____blood clotting disorder | _____mumps |
| _____allergy to bee stings | _____rubella |
| _____migraine headaches | _____asthma |
| _____mononucleosis | |

IMPORTANT THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct to the best of my knowledge and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment and necessary transportation for me or my child in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to secure and administer treatment including hospitalization for my child as named above. The completed forms may be photocopied for trips out of camp.

SIGNATURE OF PARENT OR GUARDIAN or adult camper(s) Printed name of signer

_____Date _____ _____

Witness: _____Date_____
I also understand and agree to abide with the restrictions placed on my camp activities:
Signature of minor_____

**Immunization History**
Please indicate the month and year of basic immunization and most recent booster doses

| Vaccines | Year of Basic Immunization | Year of last Booster | | |
|---|---|---|---|---|
| 1.Diphtheria<br>2.Pertussis (whooping cough)<br>3.Tetanus<br>*DPT | 1.<br>2.<br>3. | 1.<br>2.<br>3. | | |
| 1.Tetanus<br>2.Diphtheria<br>*TD | 1.<br>2. | 1.<br>2. | | |
| Tetanus | | | | |
| Oral Polio(Sabin*)<br>TOPV | | | | |
| Inject able Polio<br>SALK) | | | | |
| Measles (hard Measles, red Measles, rubeola) | | | | |
| Mumps | | | | |
| Rubella(German 3 day measles) | | | | |
| Other | | | | |
| Tuberculin test<br>Given_____<br>Most recent | | | | |
| Haemophilus Influenza b (HIB) | | | | |

**Health care recommendations by Licensed Physician**

I have examined the above camp applicant within the past two years. Date Examined_____

In my opinion, the above's condition ___DOES ___ DOES NOT preclude his/her participation in an active camp program.

HEIGHT_____ WEIGHT _____ BLOOD PRESSURE_____

The applicant is under the care of a physician for the following condition(s)

Current treatment (including current medications)

Explanation of any reported loss of conscious, any convulsions, or concussion (use back side if necessary)

Does applicant have **Epilepsy**? Y/N _____ **Diabetes** Y/N ___ **Tourette Syndrome** Y/N ____ **Bedwetting** Y/N _____

**Recommendations and restrictions while at camp:**

Any treatments to be continued at camp? _____

Any medications to be administered at camp? _____

Any medically prescribed meal plan or dietary restrictions Yes_____ No _____ If yes, please

describe:_____

Any allergies (food, drugs, plants, insects, etc.) Yes___ No____

Describe:_____

Additional Health Information_____

LICENSED PHYSICIAN SIGNATURE

_____

Address_____ City _____ State _____

Zip_____ Phone Number_____

Date of form completion_____ By_____

Initial if competed by nurse or Physician's Asst.