CAMPER HEALTH EXAMINATION FORM FOR BOYS & GIRLS

****2023****

DEVELOPED and APPROVED BY

AMERICAN CAMPING ASSOCIATION and AMERICAN ACADEMY OF PEDIATRICS

REQUIRED BY New Jersey STATE LAW

FROGBRIDGE DAY CAMP
7 Yellow Meeting House Road
Millstone Township, NJ 08510
Phone: (609) 208-9050 or (732) 786-9050
Fax (609) 208-9052

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

Name ______________________________ Birth Date ________ Age ________
Parent or Guardian ______________________________ Phone ______________
Home Address ____
In emergency notify ______________________________ Phone ______________
Relationship ____
Address ____

HEALTH HISTORY: (Check - giving approximate dates)

Frequent Colds ________________
Frequent Sore Throats ____________
Sinusitis ____________________
Abscessed Ears ________________
Bronchitis ___________________
Fainting _____________________
Stomach Upsets ______________________________
Constipation ______________________________

Kidney Trouble ____________
Bed Wetting ______________
Heart Trouble _____________
Convulsions ______________
Athlete's Foot _____________
Sleep Walking _____________
Serious Ivy, Oak or Sumac Poisoning ______________________________

Chicken Pox ______________
Measles _________________
German Measles ___________
Mumps __________________
Poliomyelitis ______________
Whooping Cough ___________
Rheumatic Fever ___________
Tuberculosis ______________
Diabetes ________________

Operations or Serious Injuries ____
General Appraisal ____
Has girl menstruated? ____________Has girl been told about menstruation? ______________________
Allergic Reactions:
Bee Sting _________ Penicillin _________ Other Drugs ______________________________

Please list any medications (prescription and/or over the counter) your child is currently taking
Name/Dosage/when given:____

Any specific activities to be encouraged? ____
restricted? ____
Does this child have any mental, physical or emotional problems ________ If yes, describe:_________

____

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

Suggestions from parents regarding health concerns **only:**

____

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 and/or surgery for my child, as named above. This form may be photocopied for use out of camp.

Signature of parent/guardian ______________________________ **Date** ________________

Parent/Guardian: Complete this side and sign above.
Physician: Complete reverse side.
This form must be returned to camp office by May 1st to complete enrollment.

Camper's Name: ________________________________ D.O.B.: ___________________

PHYSICAL EXAMINATION

To be filled out and signed below by a Licensed Physician.
(Changes must be made three months prior to camper's arrival at camp.)

Code: S- Satisfactory
NS- Not Satisfactory (explain)

Hgt. ______________________ B.P. _________________ Urinalysis test done: __________
Wt. _______________________ Hgb. test done: _________
Eyes ______________________ Extremities _______________________________________
Contacts/glasses ___________ 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 ______________________________
Hernia _____________________ General Appraisal ___________________________

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

May this child take an aspirin substitute? If so, specify adult or child substitute and dosage. ________
____

Immunizations:
D.P.T. Series ___________ Booster __________ date _______
Tetanus ___________ Booster __________ date _______
Polio Series ___________ Booster __________ date _______
Measles ______________ Booster __________ date _______
Mumps _______________ Booster __________ date _______
Rubella _______________ Booster __________ date _______
Haemphilis (Hib) ________ Booster __________ date _______
Varicella _______________
Hepatitis B ______________

Signature Examining Physician ________________________________ Date:________________

Address _________________________________

Telephone _______________________________