Camper Name_____

CAMP POINT CLEAR PHYSICIAN'S FORM P.1

This person is in satisfactory condition and may engage in all activities except those noted.

Physician's Name_____Signature_____

Address_____City_____State_____Zip_____

Camper Name_____DOB_____Parent's or Guardian's Name_____ Home Address_____City_____State_____Zip____

Home Phone_____ Mother's Cell_____ Father's Cell_____ Emergency Contact _____ Phone_____

IMMUNIZATIONS Year Primary Series Completed

D.T.P. _____ Diptheria _____ Tetanus_____ Whooping Cough_____ Oral Polio _____ Measles _____ Smallpox _____ Mumps _____ Other (Rubella)_____

TB Test _____ Year of Last Booster _____

Health History__Chicken Pox__ Measles__ German Measles __ Mumps

Physician's Form P. 2

(**check) Allergies**__Hay Fever__Asthma__Insect Sting__Food

List Foods_____ __Poison Ivy, Oak, etc

____Ear Infection __Heart Disease __Convulsions __Diabetes __Behavior __Headaches

Other (Please Explain)_____

Date Of last Examination_____ Height_____ Weight____
Appearance-Nutrition_____

Code: Satisfactory (S) Not Satisfactory (NS) Ears__Throat__Nose__ Musculoskeletal___ Heart__Teeth__ Abdomen__ Lungs__ Skin__ Urinalysis__

Other Notes_____

_____

Operation or other serious injuries (Date)_____

_____
Hospitalizations_____

Comments where applicable:
Fainting_____ Sleep Disturbances_____

Bed Wetting_____
Menstruation_____ Constipation_____
Specific Activities to be restricted _____

_____

CAMP POINT CLEAR PARENT'S HEALTH FORM **Camper's**

Name_____DOB_____Age First Day of Camp_____

Medical Insurance Information:

IMPORTANT please attach a copy of the camper's insurance card (front and back making sure the numbers are legible)

Emotional Health. Please check all that apply:

ADD or ADHD_____ Treated for emotional or behavior difficulties____
Eating Disorder____

Significant life change____**Please explain checked answers in the space below.** The camp nurse may contact you for additional information.

_____

_____

Health-Care Providers:
Primary Dr. _____ Phone_____
Dentist _____ Phone_____
Orthodontist_____ Phone_____

EMERGENCY PERMISSION: The Camp Directors, Camp Nurse, or proper authority has my permission to use their discretion in case of an emergency if the parents cannot be reached.

Parent or Guardian
Signature_____Date_____