CAMP NAZARETH

Retreat and Conference Center

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american CAMP association
enriching lives, building tomorrows

MEDICAL EXAMINATION FORM

To be filled out and signed by a **Licensed Medical Professional**

To attend Camp a medical examination is required within 12 months of the camping session. If an exam was already done in that time period, your physician may be willing to fill out the form below without an additional exam. **This form must be completed and signed by an approved, licensed medical professional (licensed physician or physician's assistant) in order to attend Camp.** Please be sure this entire form is complete. This form follows the most recent standards of the ACA and is a necessary part of the application process. Thank you for your cooperation.

I examined_____this individual on the date of_____

Name of Potential Camper/Applicant *Date of Examination*

Blood Pressure: _____ Height: _____ Weight: _____

In my opinion, the above applicant ❑ **is** or ❑ **is not** able to participate in this summer's active camp program.

The applicant is under the care of a physician for the following conditions: _____

_____

_____

_____

Which of the following has the participant had?

- ❑ Measles
- ❑ Chicken Pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: ❑ Positive ❑ Negative

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR:

DTP _____
TD (Tetanus/Diphtheria) _____
Tetanus _____
Polio _____
MMR _____
or Measles _____
or Mumps _____
or Rubella _____
Haemophilus Influenza B _____
Hepatitis B _____
Varicella _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

_____

Medications to be administered at camp (name, dosage, frequency): _____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Known Allergies: _____

_____

Description of any limitation or restriction on camp activities: _____

_____

Additional information for health care staff at the camp: _____
_____

Signature of Licensed Medical Professional: _____

Printed Name: _____ Title: _____

Address: _____

Phone: _____ Date: _____

The section below is for Camp Personnel uses only, please disregard:

Screening Record at Check-In
Date Screened: _____ Time: _____am/pm
Medications received (Prescription and non-prescription): _____
_____

Updates/additions to health history? ❑ Yes ❑ No If yes, _____
_____

Current health needs identified? _____
_____

Observational notes: _____
_____

Screened by: _____