**HEALTH HISTORY AND EXAMINATION FORM**
*Must complete pages 1 & 2
**This side to be completed by parent/guardian of minor child.*

Return to: NFA/SC
PO BOX 1592
DOYLESTOWN, PA 18901

Return hard copy form ASAP or by June 25th

**Check Session(s):**

**July 27- 30th** □ Youth Camp □ Varsity Camp

(Fri Jul 31 inclement weather make-up day if necessary)

CHILD'S NAME _____ BIRTH DATE _____ SEX _____ AGE _____
Last First Middle

HOME ADDRESS _____
Street City State Zip

HOME PHONE # _____ Parent email: _____

**PARENT/ GUARDIAN NAME(S):**

MOTHER _____ FATHER _____

MOTHER - WORK # _____ FATHER WORK # _____

MOTHER - CELL # _____ FATHER CELL # _____

**IF PARENT(S)/ GUARDIAN NOT AVAILABLE IN CASE OF AN EMERGENCY, PLEASE CONTACT:**

NAME _____ NAME _____

ADDRESS _____ ADDRESS _____

PHONE # _____ PHONE # _____

RELATIONSHIP _____ RELATIONSHIP _____

**HEALTH HISTORY:** (Check, giving approximate dates)

| | | Diseases | | Allergies | | Food | |
|---|---|---|---|---|---|---|---|
| Frequent Ear Infections | _____ | Chicken Pox | _____ | Asthma | _____ | Nut | _____ |
| Heart Defect/Disease | _____ | Measles | _____ | Hay Fever | _____ | Other | _____ |
| Convulsions | _____ | German Measles | _____ | Seasonal | _____ | | _____ |
| Diabetes | _____ | Mumps | _____ | Ivy Poisoning | _____ | | |
| Bleeding/Clotting Disorders | _____ | Mononucleosis | _____ | Insect Stings | _____ | | |
| Hypertension | _____ | | | Bee Stings | _____ | Carries Epipen? | ____ |
| Psychiatric Treatment/ Counseling | _____ | | | Penicillin | _____ | Other drugs | _____ |

Operations or serious injuries _____
Disability or chronic recurring illness / injury _____
Any specific activities to be encouraged or limited by physician's advice _____
*Current Medications (send with instructions) _____
Other diseases or details of above _____
Dietary Modifications _____

Name of Family Physician _____ Phone # _____

Name of Dentist / Orthodontist _____ Phone # _____

**HEALTH INSURANCE INFORMATION**
COMPANY NAME: _____ POLICY # _____

Suggestions or health related information for camp personnel _____

*Important – MUST be completed and signed for attendance: This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp: 1.To provide ongoing health care. 2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above. Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp. Camper agrees to abide with any restrictions placed on his/her activities.

Signature of Parent/ Guardian X_____ Date _____

← PARENT/GUARDIAN SIGNATURE REQUIRED

PHYSICIAN INFORMATION REQUIRED ON PAGE 2

## IMMUNIZATION HISTORY

**Required immunizations must be determined locally. Please record the date (month & year) of basic immunizations & most recent booster doses.**

| Vaccines | Year of Basic Immunizations | Year of Last Booster |
|---|---|---|
| Diphtheria<br>Pertussis *Whooping Cough) ] DPT*<br>Tetanus….or | 1<br>2<br>3 | 1<br>2 |
| Tetanus<br>Diphtheria TD….or | | |
| Tetanus | | |
| Oral Polio (Sabin)* TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, Rubella) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Other | | |
| Tuberculin Test given _____(most recent) | | |

## HEALTH EXAMINATION BY LICENSED PHYSICIAN

**I HAVE EXAMINED THE ABOVE APPLICANT.** **DATE EXAMINED: _____**

**In my opinion, this applicant's condition DOES _____ / DOES NOT _____ preclude his/her participation in an active program.**

**The applicant is CURRENTLY UNDER THE CARE OF A PHYSICIAN for the following condition(s): (PRINT CLEARLY)**

_____

_____

**CURRENT TREATMENT / Include MEDICATIONS** _____

_____

_____

**Explanation of any reported loss of CONSCIOUSNESS, CONVULSION OR CONCUSSION DATES:**_____

_____

**Does applicant have EPILEPSY? YES _____ NO _____ Does applicant have DIABETES? YES _____ NO _____**

**RECOMMENDATIONS and/or RESTRICTIONS WHILE PARTICIPATING:** _____

_____

_____

**Any MEDICATION to be administered (specific dosages):**

_____

**Any MEDICALLY prescribed meal plan or dietary restrictions:**

_____

**Any ALLERGIES (foods, drugs, plants, insects, etc.):**

_____

**ADDITIONAL HEALTH INFORMATION:**

**LICENSED PHYSICIAN"S SIGNATURE X**_____ **PHONE #** _____

**Address** _____

**DATE FORM COMPLETED** _____ *** By** _____

***Initial if completed by nurse or physician's assistant**