Cedarbrook Camp in Pennsylvania®
HEALTH HISTORY/EXAMINATION FORM

To be filled in by camper's parent/guardian, staff member, or adult camper.

Name _____ (Last) _____ (First) _____ (Middle)

Date of Birth _____ Age _____ Sex Male Female

Parent/Guardian (or Spouse) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ (Number/Street) _____ (City) _____ (State) _____ (Zip)

If not available in an emergency, notify:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____

OR Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____

Name of family medical/hospital insurance carrier _____

Policy or group number _____ Name on the Policy _____

Name of family physician _____ Phone _____

Name of dentist/orthodontist _____ Phone _____

HEALTH HISTORY ***(Check and/or give approximate dates)***

		Diseases		*Allergies*	
Bleeding/Clotting Disorders					
Depression		Chicken Pox		Asthma	
Diabetes		Measles		Food	
Ear Infections (frequent)		German Measles		Hay Fever	
Epilepsy or Convulsions		Mumps		Insect Stings	
Heart Defect/Diseas				Ivy Poisining, etc.	
High Blood Pressure				Penicillin	
Hypoglycemia				Other (list)	

(For female): Has this person menstruated? _____

If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special Considerations _____

List date(s) and describe:

Disability or chronic/recurring illness _____

Operations or serious injuries _____

Recent illness or hospitalization _____

FOR CAMP USE ONLY

Name _____ Date Examined _____ Cabin _____

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CURRENT MEDICATIONS

Name of medication	Dosage	When Taken	Reason for taking

NOTE: *All* medication brought to camp (listed above), including vitamins and aspirin, must be labeled with directions for use. Prescription medications *must* be in the original container with the user's name printed on the label.

IMMUNIZATIONS – Required immunizations must be determined locally. Record the date (month/year) of immunization and/or most recent booster.

IMMUNIZATION	Date Last Received	IMMUNIZATION	Date Last Received
DTP Series		Tetanus	
Measles		Tuberculin test (most recent)	
Mumps		Other	
Polio			
Rubella			

CHALLENGE ACTIVITIES PERMISSION

Certain health/medical information must be made known to the facilitator(s) conducting your challenge experience, so that they can appropriately respond if need be. This information will be held in confidence.
(Kidney transplant: yes/no Heart disease: yes/no High blood pressure: yes/no Pregnant: yes/no)
Release of Liability: I understand that aspects of the CCPA challenge program may be physically and emotionally demanding. I affirm that my child is/I am in good health and not under a physician's care for any undisclosed condition that bears upon my ability to participate in these activities. I recognize the inherent risk of injury or disability in these activities. I understand that each participant must assume the risk of injury that could result from any of these activities. I release Cedarbrook Camp in Pennsylvania, its staff members, volunteers, and board of directors from all liability for any injury to me from participating in these activities. I also give permission to receive emergency medical treatment. I also grant Cedarbrook Camp in Pennsylvania the right to use or reproduce photographs, films, video, and sound recording of the above named participant, for use in materials the camp may create.

Participant's Signature _____ **Print Name:** _____ **Date** _____

AUTHORIZATION FOR TREATMENT MUST BE COMPLETED

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, and treatment for the health of my child, and in the event that 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 my child as named above. This form may be photocopied for use outside of camp.

Parent Signature _____ **Print Name:** _____ **Date** _____

Witness _____ **Date** _____

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HEALTH EXAMINATION (To be completed by a licensed physician. Exam required by camp.)

Examination is for determining fitness to engage in camp activities. Reference to earlier examination for some other purpose is acceptable.

I have examined _____
Name

on _____ and reviewed the health history.
Date

Height _____ Weight _____ Blood Pressure _____

In my opinion, the applicant's condition does ☐ does not ☐ hinder his or her participation in an active camp program.

Does applicant have any conditions which might limit participation in swimming, hill climbing, team sports, and other strenuous activities? Yes _____ No_____ Explain _____

_____

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

_____

Current treatment (include current medications):_____

_____

Recommendations while at camp:

Treatment to be continued at camp:_____

_____

Medication to be administered at camp:_____

_____

Medically prescribed meal plan or diet restrictions:_____

_____

Any restrictions? (swimming, strenuous activity)_____

_____

_____
Examining Physician's Signature

_____
Print Physician's Last Name

_____
Phone

_____
Street Address

Date of Form Completion _____

_____
City **State** **Zip**

By _____
Initial if completed by nurse or assistant.

FOR CAMP USE ONLY

Name_____

Date Examined_____

Cabin_____