CAMP HEALTH EVALUATION

Name (Last, First, MI): _____

Name of Camp _____

Date of Birth ___/___/___ Sex _____

Address and Zip Code: _____

Parent or Guardian Telephone:

Parent or Guardian Name and Address: _____

Day ( ) _____

Evening ( ) _____

HEALTH HISTORY

Past illnesses, surgery, hospitalizations. ***Please give approximate dates.***

Medicine child takes now:

Will child need to take during camp? _____

IMMUNIZATIONS AND DATES

DPT:	#1	OPV:	#1	HIB:	#1	HepB:	#1	MMR:	#1		
	#2		#2		#2		#2		#2		
	#3		#3		#3		#3		Rubella		
	#4		#4								
	#5										

Chicken Pox: _____ Other _____ _____

EXAMINATION Normal:	Yes	No	Comment
Height			
Weight			
Blood Pressure			
General Appearance			
Head Lice Check			
Eyes			
Ears, Nose			
Mouth, Throat			
Neck			
Lymph Nodes			
Lungs			
Cardiovascular			
Genitalia, Breasts			
Abdomen			
Extremities, Joints			
Spine			
Skin			
Neurological			
Developmental/Behavioral			
Nutrition			

SCREENING TESTS Normal:	Yes	No	Comment
Vision			
Hearing			
Dental			
Caries			
Missing Permanent Teeth			
Infection			
Protrusion			
HGB/HCT			
Sickledex			
Lead			
Other lab tests			

TB Skin Test: Mantoux, PPD (not tine)

Date Given _____ Date Read _____

Size (mm) _____ Other Tests (optional) _____

SPECIAL INSTRUCTIONS (Include **allergies, activity restrictions, special diet,** etc.):

RECOMMENDATIONS FOR FOLLOW-UP (Please complete. Camp program will assist parent with follow-up evaluation and treatment):

Signature _____ Address _____

Name _____ _____

Date _____ Telephone: _____

Date of exam, if different: