

CAMP TURK
The Masonic Youth Camp

CAMP HEALTH EXAMINATION FORM
for CHILDREN, YOUTH and ADULTS

First Name _____ M/I _____ Last Name _____
 Date of Birth _____ Sex _____ Age _____ SS # _____
 Parent or Guardian _____ Relationship _____
 Home Address _____
 Home Phone # () _____ Work # () _____ Cell # () _____

If not available in an emergency notify:

Name _____
 Address _____
 Home Phone # () _____ Work # () _____

Insurance Information: (Please attach a copy of you insurance card)

Name of Insurance _____
 Address of Insurance Co. _____
 Policy # _____ Group # _____
 Name of person carrying the insurance _____
 Employer _____
 Employers Address _____
 Date of Birth of Insured _____ SS # of Insured _____
 Authorization for release of information to above named insurance carrier:
 (Signature) _____

*Your personal medical policy is your child's primary coverage.
 All registered campers are covered by excess coverage accident insurance while at camp.*

***** PARENT'S AUTHORIZATION – MUST BE COMPLETED FOR ATTENDANCE *****

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

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, anesthesia or surgery for my child as named above.

Signature _____ Date _____

HEALTH HISTORY - To be completed by parent / guardian

(Check - giving approximate dates)

_____ Ear infections	_____ Psychiatric treatment	_____ Allergies	_____ Diseases
_____ Heart defect / disease	_____ Mononucleosis	_____ Hay fever	_____ Chicken pox
_____ Convulsions	_____ Sleep walking	_____ Poison ivy	_____ Measles
_____ Diabetes	_____ Bed wetting	_____ Insect stings	_____ German measles
_____ Bleeding / clotting disorders	_____ Fainting	_____ Penicillin	_____ Mumps
_____ Hypertension	_____ Asthma	_____ Other drugs	

Operations or Serious Injuries (Dates) _____
 Chronic or Recurring Illness _____
 Other Diseases or Details of Above _____
 Any specific activities to be encouraged? _____ restricted? _____
 Suggestions from parents _____
 For Females: Has this person menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special considerations: _____

ALL OF THE FOLLOWING INFORMATION MUST BE FILLED OUT BY A LICENSED PHYSICIAN

(This information can not be older than 12 months old!)

IMMUNIZATION HISTORY – You MUST attach a copy of your child’s immunization records!!!

MEDICAL EXAMINATION

BIRTHDATE _____	EARS _____	URINE _____
HEIGHT _____	NUTRITION _____	ALLERGIES _____
WEIGHT _____	BLOOD HMOG (DESIRABLE) _____	ANIMALS _____
POSTURE AND SPINE _____	NOSE _____	FOODS _____
FEET _____	THROAT – TONSILS _____	DRUGS _____
SKIN _____	TEETH – POSITION _____	OTHER _____
SCABIES _____	HEART _____	CURRENT CONDITIONS _____
ATHLETE’S FOOT _____	MURMUR _____	(DIABETIC, EPILEPSY, ECT.) _____
IMPETIGO _____	BLOOD PRESSURE _____	_____
INFECTION _____	LUNGS _____	_____
PEDICULOSIS _____	ABDOMEN _____	_____
EYES _____	GENITALS _____	_____
DISCHARGE _____	HERNIA _____	_____
GLASSES _____		

Recommendations and restrictions while in camp:

Special diet _____
Special medicine (name it) _____
Is parent sending it? _____
Swimming, diving _____ Strenuous activity _____
Other _____

I have examined the person herein described and have reviewed his health history. It is my opinion that he is physically able to engage in camp activities, expect as noted above. I have attached instructions on medications, treatments, and diet (see next page). The Camp Turk Health Director has my permission to dispense as directed. In the event the Health Director is not available to dispense medication, his / her designated representative may dispense medication as prescribed.

Signature of Examining Physician _____
Address _____
Telephone Number () _____
Date _____

**** NEW****

**Any over-the-counter medication that your child may need
must have a doctors prescription or it can not be given at camp!!!**

List Medication(s)	Time(s)	Dosage(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***** (this information needs to be the same as the bottle) *** This includes over the counter medications!**