

CAMP HEALTH EXAMINATION FORM FOR CHILDREN, YOUTH, AND ADULTS

Please Return Completed Form To: Marist Upward Bound
 3399 North Road
 Poughkeepsie, NY 12601-1387

2008-2009

This side of form is to be filled in by parent and checked with physician at the time of examination. **(Please Print Clearly)**

Student's Name _____
First Last MI

Birthdate _____ Age _____ Health Policy and # _____

Home Address _____
Street & Number City NY Zip Code

Mother/Guardian's Name _____
First Last

Home Phone (____) _____ Work Phone (____) _____ Cell/Pager (____) _____

Father/Guardian's Name _____
First Last

Home Phone (____) _____ Work Phone (____) _____ Cell/Pager (____) _____

HEALTH HISTORY (Check and /or give approximate dates)

Ear infections _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Poison Ivy, etc. _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Asthma _____

Operations or Serious Injuries (dates) _____
 Chronic or Recurring Illness _____
 Other Diseases or Details of Above _____
 Any Specific Activities to be Restricted? _____

IMPORTANT: Please notify the program nurse if this camper is exposed to any communicable disease during the three week period prior to camp attendance.

PARENT AUTHORIZATION: (The statements below must be read and signed. Students cannot receive medical treatment without parental authorization.) Parents are responsible for providing the Director with written notification of where they can be reached if they will be unavailable at home/work due to travel.

I hereby consent to have the Marist College Project Upward Bound Staff, or other medical professionals designated by the Director to secure treatment for my child in the event that I cannot be contacted; or if in the judgement of medical professionals, immediate attention is required prior to my being contacted.

Parent's Signature _____ **Date** _____

If I am not available in an emergency please contact: *(Please print clearly.)*

Name Relationship (____) _____
Phone Number

Name Relationship (____) _____
Phone Number

STUDENT'S NAME _____

IMMUNIZATION HISTORY: To be filled out by parent/physician. Required immunization must be determined locally. Record dates of basic immunizations and most recent booster doses.

DTP Series _____ / _____ / _____ Booster _____ Tetanus Booster _____
Polio OPV (Sabin) _____ Booster _____ Typhoid _____
Measles Vaccine (Live) _____ Tuberculin Test _____
German Measles (Rubella) _____ Mumps Vaccine (Live) _____
Smallpox _____ Other _____

MEDICAL EXAMINATION: To be filled out by licensed physician. This examination should be performed within 12 months of arrival at camp. Examination for some other purposes within this period is acceptable. Examination is for determining fitness to engage in strenuous activities. (Pregnant students are not permitted to participate in the residential component.)

Hgt. _____ Wgt. _____ B.P. _____ Hgb. Test _____ Urinalysis _____
Eyes _____ Extremities _____
Glasses _____ Posture (spine) _____
Ears _____ Skin _____
Nose _____ Allergy _____
Throat _____ Lungs _____
Teeth _____ Abdomen _____
Heart _____ Hernia _____

General Appraisal _____

For Females: Has patient begun menstruation? _____ If not, has she been told about it? _____

If menstruation has begun, is patient's history normal? _____

Special Considerations _____

Recommendations and Restrictions While in Camp:

Special Diet _____

Special Medicine (Name) _____ Is Parent Sending Medicine? _____

Swimming/Diving _____ Strenuous Activity _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Examining Physician's Signature

Date

Examining Physician's Name (Print)

Telephone Number