

Tidal River Christian Camp
<http://www.trcc.info>
 Haddam, Connecticut
 Youth Camp Health Examination Record

Expiration Date

To Be Completed By Parent or Guardian

Name _____ Sex ____ Age ____ Birth Date _____
 (last) (first)

Address _____ Phone _____
 (street) (town) (state) (zip)

In Emergency Notify _____ Relationship _____

Address _____ Phone _____

<u>Camper Medical History (check)</u>	<u>Allergies</u>	<u>Chronic/Recurring Illness</u>
Chickenpox _____ Measles _____	Hay Fever _____ Insect Sting _____	Earaches _____ Throat Problems _____
German Measles _____ Mumps _____	Asthma _____ Drugs (specify) _____	Sinus _____ Infections _____
Whooping Cough _____ Other _____	Ivy, Oak, Etc. _____ Foods (specify) _____	Heart _____ Stomach _____
Details of above _____		Epilepsy _____ Rheumatic Fever _____
		Diabetes _____ Menstrual _____
Medications Being Taken (name and explain) _____		Problems _____

Operations, Injuries, Special restrictions (explain and give dates) _____

<u>Immunization</u>	<u>Date</u>	<u>Booster</u>
Diphtheria	_____	_____
Tetanus	_____	_____
Pertussis	_____	_____
Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Other	_____	_____

Parent or Guardian Me Authorization (required for all persons under age 18) This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. If 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 order injection, anesthesia for surgery for the person named above.

Signature _____ Date _____

Physical Examination: To be completed By A Licensed Physician: (Code: 1=Satisfactory 2=Not Satisfactory 0=Not Examined)

Height _____	Weight _____	B.P. _____	Skin _____	Nose _____
Eyes _____	Glasses _____	Contacts _____	Required _____	Condition _____
Ears _____	Hearing Right _____	Left _____		
Throat _____	Teeth _____	Heart _____	Lungs _____	Skeletal _____
Abdomen _____	Genitalia _____		Hernia _____	Extremities _____
Test: Urinalysis Glucose % _____	Albumin % _____		Tuberculin Testing (type) _____	

If indicated, Blood Count _____

Restrictions, Limitations (including diet) _____

Medications _____

Recommendations _____

The above named person is in satisfactory condition and may engage in all camp activities except as noted.

Date of Exam _____ Examining Physician _____

Telephone _____ Print Physician's Name _____

State Licensed In _____ Lic. # _____ Address _____