For Office Use

Health Examination Form for Children, Youth and Adults Attending Camps FM 12

Suggested for resident camp use.

Developed and approved by the
American Camping Association®
with the American Academy of Pediatrics

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

Year

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health exam must be completed by approved licensed medical personnel at least every two years.

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social Security number of participant _____ Gender: ☐ Male ☐ Female

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business address _____ Phone _____

Cabin or Group

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Health Care Recommendations by Licensed Medical Personnel

I examined the above camp participant on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Name