

**CAMP ASHMERE**  
**HEALTH and MEDICAL**  
(to be completed by parent/guardian)

Camper's Name \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

Location and phone number of parent/guardian during camp session:

\_\_\_\_\_

Designated ADULT Emergency Contact \_\_\_\_\_

Phone number \_\_\_\_\_

Name, address, and phone number of camper's physician \_\_\_\_\_

\_\_\_\_\_

Name, address, and phone number of camper's dentist \_\_\_\_\_

\_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Illnesses \_\_\_\_\_

Allergies (please list) \_\_\_\_\_

Is your child taking any medications? \_\_\_\_\_ Medicine \_\_\_\_\_

Reason for taking \_\_\_\_\_

Special concerns (please check if applicable)

Special diet \_\_\_\_\_ Constipation \_\_\_\_\_ Sleepwalking \_\_\_\_\_

Bedwetting \_\_\_\_\_ Headaches \_\_\_\_\_ Stomach aches \_\_\_\_\_

Other \_\_\_\_\_

Any limitations on full participation in all camp activities? \_\_\_\_\_

(If yes, please describe) \_\_\_\_\_

\_\_\_\_\_

In case of emergency, I hereby give my permission to the Director of Camp to authorize any emergency treatment for my child deemed necessary by the attending doctor. I understand all efforts will be made to contact me before such authorization is given.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian)

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

CAMP ASHMERE

PHYSICIAN'S EXAMINATION

Camper's Name \_\_\_\_\_ Date \_\_\_\_\_

D.O.B. \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ B/P \_\_\_\_\_ Vision \_\_\_\_\_

Significant past medical history: None or \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Current medical problems: None or \_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A complete physical examination has been performed on this patient on \_\_\_\_\_.  
(Date)

The patient was found to be in good health.  
Exemption: \_\_\_\_\_  
\_\_\_\_\_

Any limitations on full participation in all camp activities? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

Scoliosis screening: Negative\_\_\_\_ Positive\_\_\_\_

Immunizations: Complete form or attach a copy of the state immunization form used for school.

DTaP/DTP							
IPV/OPV							
HIB							
Hepatitis B							
MMR							
Varicella							
TB test date		Type		Results			
Other							

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_