

PHYSICAL EXAMINATION—To be filled out by licensed physician

(Within six weeks prior to camper's arrival at camp)

Code: V — Satisfactory
Code: X — Not Satisfactory (explain)

Hgt. _____ B.P. _____ Urinalysis test done _____

Wt. _____ Hgb. test done _____

Eyes _____ Extremities _____

glasses _____ Posture (Spine) _____

Ears _____ Skin _____

Nose _____ Allergy—Please specify _____

Throat _____

Teeth _____

Heart _____

Lungs _____ **General appraisal:** _____

Abdomen _____

Genitalia _____

Hernia _____

Recommendations and Restrictions _____

IMMUNIZATIONS:

D.P.T. Series _____: booster _____ date _____ Tetanus booster _____ date _____

Polio Series _____; booster _____ date _____ Smallpox _____ date _____

Typhoid Series _____; booster _____ date _____ (optional)

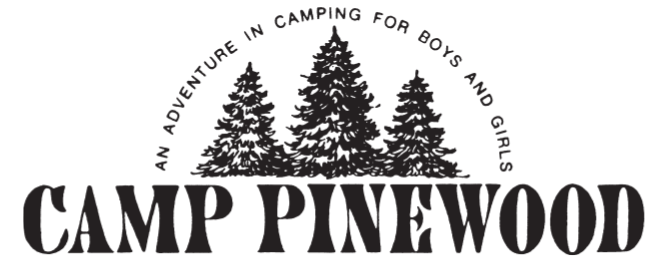
Measles Vaccine _____ date _____ Hepatitis _____ date _____

Examining Physician

Telephone _____ Address _____

Date _____

CAMPERS HEALTH EXAMINATION FORM FOR BOYS



Hendersonville, North Carolina

(This side to be filled in by parent and checked with physician at time of examination.)

Name _____ Birth Date _____ Age _____ Sex _____

Social Security # _____ Parent or Guardian _____

Address _____

Home Phone # _____ F-Bus # _____ M-Bus # _____

HEALTH HISTORY:

Parents...Should you check (✓) any of the below, please provide us with an explanation (in the space provided) as to how you and/or your physician best treat these conditions at home. This detailed information will be invaluable to our medical staff.

Frequent Colds _____ Constipation _____

Frequent Sore Throats _____ Fainting _____

Prone to: Ear Infections _____ Athlete's Foot _____

Sinusitis _____ Headaches _____

Bronchitis _____ Sleep Walk _____

Upset Stomach _____ Bedwetting _____

Operations or Serious Injuries _____

Allergic Reactions: Bee Sting _____ Penicillin _____ Poison Ivy, Oak or Sumac _____

Other _____

EXPLANATIONS:

_____ (Continue on Page 3)

Please give approximate dates: Chickenpox _____ Measles _____ German Measles _____ Mumps _____

_____ Poliomyelitis _____ Whooping Cough _____ Rheumatic Fever _____ Diabetes _____

IMPORTANT:

Please notify the camp if this child is exposed to any communicable disease during the three weeks prior to camp attendance.

(Continued, to be filled in by parent and checked with physician at time of examination.)

Should your child require a routine visit to the doctor, dentist, or orthodontist, fees must be paid at the time service is rendered. You will be notified on the day of service and then mailed copies of all paid bills for medical services and prescriptions.

IMPORTANT...MUST COMPLETE AND SIGN

Camper's Name (print) _____

Parent's Name (print) _____

Credit Card Number _____ (circle one) MC VISA

Expiration Date _____ Authorized Signature _____

Fax Number _____ E-mail _____

Camper Medication Record

This summer, we will require prescription medication and daily/routine non-prescription medication (example: Claritin) that is in PILL FORM to be prepackaged, sealed, labeled and sent to camp prior to arrival day. You must supply CampMeds with your child's actual prescription(s) and/or instructions in regard to non-prescription daily meds at least 30 days prior to arrival. CampMeds individually packages medication by dosage and labels it with date and time of administration. NOW IS THE TIME TO REGISTER AT CampMeds.com SO THAT YOU CAN BEGIN THIS IMPORTANT PROCESS. Any questions, call CampMeds (1-954-577-0025)

PLEASE REMEMBER: With the exception of auto arrivals, all other medication not mailed to us from CampMeds must be sent to camp in advance. If feasible, place in zip lock bag and ship in camper's duffle bag. This TSA airport security regulation will be strictly enforced....parents will no longer be able to give medication in the form of liquids (incl. syringes), creams, ointments, pills or gels to the camp escorts at the airport.

Will your child be taking any Non-Pill prescription or other medication while at camp? Yes _____ No _____

Does your child require prescription medication in pill form (Note: you must register with CampMeds)? Yes _____ No _____

If "yes" to either question, please list all medicines below and complete all information requested.

Name of medication: _____

Dosage instructions: _____

Reason for taking medication: _____

Name of medication: _____

Dosage instructions: _____

Reason for taking medication: _____

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Dosage instructions: _____

Reason for taking medication: _____

NOTE: All non-pill prescription medications for campers must be in the original container with the prescription label attached with the camper's name. The directions on the label must correspond to the dosage instructions listed on this form. Do not send common over the counter medicines to camp.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN CONTACT NUMBERS:

Orthodontist _____ Other Specialist _____

Phone _____ Phone _____

Ophthalmologist _____ Other Specialist _____

Phone _____ Phone _____

IMPORTANT.....Must COMPLETE and Sign

Should an office visit be necessary, it is understood that the camp's selected medical personnel will perform treatment and order routine tests including x-rays. In case of medical emergency, the camp will secure any treatment deemed necessary including injection, anesthesia or surgery. Parent(s) or guardian will assume financial responsibility for all treatment and guarantee child's medical policy (health/accident/major medical) will be in force during his or her stay at camp. Camp Pinewood does not maintain health or accident insurance for campers.

Name of Company _____ Telephone # _____

Policy under what name? _____ Deductible Amt. \$ _____

Signature of parent or guardian necessary _____ Date _____

PLEASE STAPLE PHOTOCOPY OF YOUR INSURANCE CARD HERE (BOTH SIDES)

COMMENTS: _____

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Typhoid Series _____; booster _____ date _____ (optional)

Measles Vaccine _____ date _____ Hepatitis _____ date _____

Examining Physician _____

Telephone _____ Address _____

Date _____

CAMPERS HEALTH EXAMINATION FORM FOR GIRLS



(This side to be filled in by parent and checked with physician at time of examination.)

Name _____ Birth Date _____ Age _____ Sex _____

Social Security # _____ Parent or Guardian _____

Address _____

Home Phone # _____ F-Bus # _____ M-Bus # _____

HEALTH HISTORY:

Parents...Should you check (✓) any of the below, please provide us with an explanation (in the space provided) as to how you and/or your physician best treat these conditions at home. This detailed information will be invaluable to our medical staff.

- | | |
|--------------------------------------|----------------------|
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| Prone to: Ear Infections _____ | Athlete's Foot _____ |
| Sinusitis _____ | Headaches _____ |
| Bronchitis _____ | Sleep Walk _____ |
| Upset Stomach _____ | Bedwetting _____ |
| Operations or Serious Injuries _____ | |

Allergic Reactions: Bee Sting _____ Penicillin _____ Poison Ivy, Oak or Sumac _____

Other _____

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Poliomyelitis _____ Whooping Cough _____ Rheumatic Fever _____ Diabetes _____

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CAMPERS NAME _____ THIS LINE FOR CAMP USE ONLY _____ Date Examined _____ Cabin _____