Rein teen tours

Medical Form

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Developed by
THE AMERICAN CAMPING ASSOCIATION
In consultation with the American Medical Association
and the American Academy of Pediatrics

AN ADVENTURE OF A LIFETIME

Parents are to fill out this side of the form as completely as possible. Be sure to enter all information requested on this page. The reverse side of this form is to be completed by your physician.

Teenager's Full Name ____________________ Birthdate __________ Sex __________

Age __________ Phone Number ____________________ Business Phone Number ____________________

Home Address ____________________ Parent or Guardian's Name ____________________

City ____________________ State __________ Zip Code __________

Tour / Program ____________________

In an emergency, we must be able to reach you or someone who can reach you. Therefore, we must have the names and phone numbers (including area codes) of people who can contact you at all times.

1. Name ____________________ Phone ____________________

2. Name ____________________ Phone ____________________

HEALTH HISTORY: (check-giving approximate dates)

Ear Infection __________ Hay Fever __________ Chicken Pox __________

Convulsions __________ Insect Stings __________ Diabetes __________

Penicillin __________ Behavior __________ Other Drugs __________

Asthma __________

Operations or Serious Injuries (Dates) ____________________

Chronic or Recurring Illness ____________________

Prescription Drugs being brought on tour (list drug and purpose) ____________________

____

____

MEDICAL INSURANCE

Insurance Carrier ____________________

Group or Plan # ____________________

Subscriber ID # ____________________

Please attach a photocopy of your Medical Insurance Card to this form.

PARENT'S AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the trip director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Parent's Signature ____________________ Date ____________________

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series ________________ booster ________________ Tetanus Booster ________________

Polio OPV ________________ booster ________________ Typhoid ________________

Measles Vaccine ________________ Tuberculin Test ________________

German Measles ________________ Mumps Vaccine ________________

Chicken Pox ________________ Other ________________

MEDICAL EXAMINATION – to be filled out by licensed physician

This examination should be performed within twelve months of departure. Examination for some other purpose within this period is acceptable.
Examination is for determining fitness to engage in strenuous activities.

Hgt. ________ Wt. ________ B.P. ________ Hgb Test ________ Urinalysis ________

Eyes ________________

Ears ________________

Nose ________________

Throat ________________

Teeth ________________

Heart ________________

Lungs ________________

Abdomen ________________

Hernia ________________

Extremities ________________

Posture (Spine) ________________

Skin ________________

Allergy: Please specify ________________

____

____

General Appraisal ________________

____

____

(For Girls)

Has this person menstruated? ________________

If so, is her menstrual history normal? ________________

If not, has she been told about it? ________________

Recommendations and restrictions for this summer.

Special diet ________________

Special Medicine (name it) ________________

Swimming, diving ________________

Strenuous Activity ________________

Other ________________

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 all activities, except as noted above.

Examining Physician ________________ Telephone ________________

Date ________________ Address ________________ Zip Code ________________