



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

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 _____

AN ADVENTURE OF A LIFETIME

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 _____