



# Camp Kiowa Physical Form

## HEALTH HISTORY AND EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS ATTENDING CAMPS

Terms: \_\_\_\_\_

Please return to: P.O. Box 425286  
Denton, TX 76204  
Fax: (940) 668-0536

*This side to be filled in by parent/guardian*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business \_\_\_\_\_ Phone \_\_\_\_\_

Second Parent, Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, please notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Group, ID or Account Number \_\_\_\_\_ Policy Holder \_\_\_\_\_

Address & Phone Number of Carrier \_\_\_\_\_

### HEALTH HISTORY: (check and give approximate dates)

Frequent Ear Infections _____	Mononucleosis _____	<b>Allergies</b>
Heart Defect/Disease _____	<b>Diseases</b>	Hay Fever _____
Convulsions _____	Chicken Pox _____	Ivy Poisonings _____
Diabetes _____	Measles _____	Penicillin _____
Bleeding/Clotting Disorders _____	German Measles _____	Insect stings _____
Hypertension _____	Mumps _____	Other Drugs _____
Asthma _____	Other _____	Other _____
Nocturnal enuresis _____		

Has this camper ever required any psychiatric counseling or hospitalization? \_\_\_\_\_  
had operations or serious injury? (dates) \_\_\_\_\_

Does this camper have disabilities or recurring illnesses: \_\_\_\_\_

Activities to be encouraged or limited by physician's advice: \_\_\_\_\_

Dietary modifications: \_\_\_\_\_

Current medication (send with instructions): \_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Suggestions or health-related information for Camp Kiowa staff: \_\_\_\_\_

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp:

1. To provide ongoing health care; and, 2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above. Furthermore, in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

SIGNATURE of parent or guardian \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor: \_\_\_\_\_ Date: \_\_\_\_\_

**Over/Next**

# IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster doses:

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough) DPT	2	2
Tetanus	3	
or		
Tetanus		
Diphtheria TD		
or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Haemophilus influenza b (HIB)		
Other		

Tuberculin test given \_\_\_\_\_ (most recent)

## Health Examination by Licensed Physician:

Date Examined: \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Blood pressure \_\_\_\_\_

In my opinion, the above's condition  does preclude  
 does not preclude  
his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Current treatment (include current medications): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Does applicant have epilepsy? Yes  No  Does applicant have diabetes? Yes  No

## Recommendation and Restrictions While at Camp:

Any treatment to be continued at camp: \_\_\_\_\_

Any medication to be administered at camp (specific dosages): \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any allergies (food, drugs, plants & insects, etc.): \_\_\_\_\_

Additional Health Information:

Licensed Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street & Number City State Zip

Date of Form Completion \_\_\_\_\_ By \_\_\_\_\_