Camp America Medical Form

Office Use Only Date _____ Entered by _____

TO BE COMPLETED BY APPLICANT ONLY

Membership number ☐☐☐☐☐☐☐

First Name ..... Last Name .....

Height ..... Weight ..... Age ..... Date of birth ...../...../..... M ☐ F ☐

Emergency Contact

First Name ..... Last Name .....

Contact Phone Number (including Country Code) .....

Camp America must be notified if you are exposed to a communicable disease/serious injury or of any other changes to your general medical condition after completion of this form, including sprained/broken limbs which may impair performance. I confirm the information on this form is correct to the best of my knowledge. Should an emergency situation arise, I authorise any medical provider to release information regarding my condition to Camp America or their insurance provider/emergency services and I understand they can contact my next of kin or my nominated emergency contact without my prior consent. I confirm I have read the insurance privacy policy (see www.culturalinsurance.com link at bottom of "About US" section).

Signature ..... Date .....

TO BE COMPLETED BY THE PHYSICIAN ONLY

Detail any chronic/recurring illnesses, menstruation problems, (frequency) .....

.....

Detail any operations, serious injuries, serious sicknesses or any other pre-existing medical conditions (give approximate dates)

.....

Detail any hospitalisations with more than three days of admission (give approximate dates) .....

.....

Detail any mental illness/eating disorder/self harm (give approximate dates) .....

.....

To your knowledge has the applicant ever been a victim of: Physical Abuse? Yes ☐ No ☐ Sexual Abuse? Yes ☐ No ☐

Are there any emotionally/mentally related problems that would prevent this applicant from caring for children? Yes ☐ No ☐

*If you have answered **YES** to this question, please attach a letter detailing the nature of the illness, when and why it occurred, for how long, and if any medication was or still is being taken.*

Recommendations for Physical Activity: Limited ☐ Unlimited ☐ *Please explain if limited*

Do you have access to the patient's full history? Yes ☐ No ☐

How long have you been treating the patient? .....

Please provide name and dosages of all medications applicant is prescribed to take and to which condition they relate. (Patient will need up to three months supply of all medications)

Medicine ..... Condition .....

Doctors will not be held liable for the information or opinions provided in good faith to Camp America.

Doctor's Signature ..... Date: .....

Please Print Name .....

Address .....

Phone Number .....

Please Stamp

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Immunisations/Tests:			Date	Booster
Diphtheria Toxoid	Yes ☐	No ☐	.....	.....
Tetanus Toxoid	Yes ☐	No ☐	.....	.....
Whooping cough Vaccine	Yes ☐	No ☐	.....	.....
Smallpox Vaccine	Yes ☐	No ☐	.....	.....
Typhoid Vaccine	Yes ☐	No ☐	.....	.....
Rubella Vaccine	Yes ☐	No ☐	.....	.....
Polio (Sabin) Vaccine	Yes ☐	No ☐	.....	.....
Measles Vaccine	Yes ☐	No ☐	.....	.....
Mumps Vaccine	Yes ☐	No ☐	.....	.....
Hepatitis B Series	Yes ☐	No ☐	.....	.....
Meningitis Vaccine	Yes ☐	No ☐	.....	.....
Tuberculin test given	Yes ☐	No ☐	.....	.....

Any Problems with the Following:

	Past	Current	Date		Past	Current	Date
Orthopedics	☐	☐	.....	Fainting	☐	☐	.....
Hearing	☐	☐	.....	Night Terrors	☐	☐	.....
Throat	☐	☐	.....				
Dental	☐	☐	.....	**Allergies:**			
Heart	☐	☐	.....	Medications	☐	☐	.....
Lungs	☐	☐	.....	Foods	☐	☐	.....
Skin	☐	☐	.....	Pets/Animals	☐	☐	.....
Migraines	☐	☐	.....	Fabric/Materials	☐	☐	.....
Depression	☐	☐	.....	Penicillin	☐	☐	.....
OCD	☐	☐	.....	Hay Fever	☐	☐	.....
Attempted Suicide	☐	☐	.....	Hives	☐	☐	.....
Sleep Walking	☐	☐	.....	Insect Sting	☐	☐	.....

Susceptibilities:	Yes	No
Convulsions/Epilepsy	☐	☐
Date of last seizure	...../...../.....	
Diabetes	☐	☐
Food Sensitivity	☐	☐
Sinus Infections	☐	☐
Bronchitis	☐	☐
Ear Infections	☐	☐
Other		
.....		
.....		

Past Illnesses:	Yes	No
Cancer	☐	☐
Concussions/Head Injuries	☐	☐
Rheumatic Fever/Heart Disease	☐	☐
Tuberculosis	☐	☐
Chicken Pox	☐	☐
German Measles	☐	☐
Mumps	☐	☐
Whooping Cough	☐	☐
Asthma	☐	☐
Other		

Send the original to your local Camp America office, AND take a photocopy of this form with you to camp. – UNITED KINGDOM – 37A Queen's Gate, London, SW7 5HR
POLAND – ul. Wierzbowa 9/11 p.315, 00-094 Warszawa • AUSTRALIA – PO Box 1319, Darlinghurst, NSW1300, Sydney, Australia