Physical Examination/Medical History Form
2016 Assumption College Camps (*for campers/staff over age 18*)

Name of Assumption College Camp: ____

Last Name: ______________________________ **First Name:** __________________________________

Date of Birth: _____/______/_______ **Sex:** ________

Home Address: ____

Home City: ___________________________________ **State:** ________ **Zip Code:** ______________

HEALTH HISTORY
***Please fill in dates where appropriate*.**

Illness	***Allergies	Disease
Frequent Ear Infections____________	Hay Fever_________	Chicken Pox_______
Heart Defect/Disease______________	Ivy Poisoning______	Measles__________
Convulsions______________	*Insect Stings_____	German Measles________
Diabetes_________________	Medicine_______	Mumps________
Bleeding/Clotting Disorders_________	Foods__________	
**Asthma___________	*What Insects_______	

**Please describe care necessary to handle asthma (i.e.-use of inhaler)______________________________
***If Epi-Pen is required to handle allergic reaction, family must supply one

Operations or serious injuries (with dates):____

Chronic or recurring illness: ____

Any specific activities to be restricted?
____

Name of Campers Dentist? ____Phone____________________

Name of Campers Doctor?_______________________________________ Phone ____________________

Name of Medical Insurance Carrier: ____________________________Policy#____________________

Address: ______________________________________Phone______________________________ ____

IMMUNIZATION HISTORY AND DATES

DPT 1.____________ **2.____________** **3.____________** **4.____________** **5.____________** **Tdap.** **______________**	**Polio 1. ____________** **2.** **____________** **3.** **____________** **4.** **____________**	**MMR (combined)** **1.________________** **2.________________**	**Meningococcal** **(not required)** **1.__________________**
History of Chicken Pox **(Not required)** **Yes ______________** **Date______________** **NO_______________**	**HIB (not required)** **1.______________** **2.______________** **3.______________** **4.______________**	**Hepatitis B Series (only for children born on or after 1/1/92)** **1.______________** **2.______________** **3.______________**	

Medical Examination --To be filled in by a licensed physician. This examination should be performed within one calendar year of arrival at the Assumption College Camp. Examination for some other purpose within this period is acceptable

Code: **V**-Satisfactory **X**-Not Satisfactory (explain) **O**-Not Examined

Ht. __________ Wt. ______________ Blood Pressure: __________ Urinalysis: ____________

Eyes_________ Lungs____________ Allergy_______________

Please describe degree of allergic reaction and treatment:

____

Glasses________________ Abdomen___________________
Contacts________________

Ears__________ Hernia__________________ General Appraisal_____________________
Nose_________ Extremities______________
Throat_________ Posture (spine) ____________
Heart__________ Skin: _____________________ Genitalia: __________

Special Diet: ____

Current Medications: ____

I have examined the person described herein and have reviewed the health history. It is my opinion that this person is physically able to engage in program activities, except as noted above.

Examining Physician: ___________________________________Date:_______________

Please Print Physician's Name: ____

Address: ____Phone:___________________