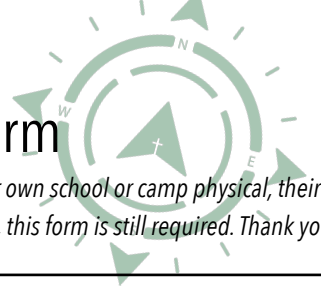


Camp Northfield

Health History and Examination Form



Please fill this form out completely and accurately. If your child's pediatrician provides you with a copy of their own school or camp physical, their signature on this form is not required. Even if you choose to provide us with a copy of a school or camp physical, this form is still required. Thank you!

FULL NAME: _____
 BIRTHDATE: _____ AGE: _____ GRADE ENTERING: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 PARENT / GUARDIAN NAME: _____
 E-MAIL: _____ CELL NUMBER: _____
 EMERGENCY CONTACT (other than above): _____
 RELATION TO CAMPER: _____ CELL NUMBER: _____

DISEASES	ALLERGIES	HISTORY
<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> NO KNOWN ALLERGIES	<input type="checkbox"/> FREQUENT EAR INFECTIONS
<input type="checkbox"/> MEASLES	<input type="checkbox"/> IVY POISONING	<input type="checkbox"/> HEART DEFECT/ DISEASE
<input type="checkbox"/> GERMAN MEASLES	<input type="checkbox"/> INSECT STINGS	<input type="checkbox"/> CONVULSIONS
<input type="checkbox"/> MUMPS	<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> DIABETES
<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER DRUGS	<input type="checkbox"/> BLEEDING/ CLOTTING DISORDERS
	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HYPERTENSION
	<input type="checkbox"/> FOOD	<input type="checkbox"/> BED WETTING
	<input type="checkbox"/> HAY FEVER	<input type="checkbox"/> ANXIETY/ DEPRESSION

EXPLAIN ANY OF THE ABOVE AS NECESSARY: _____

OPERATIONS OR SERIOUS INJURIES: _____

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN'S ADVICE: _____

DIETARY MODIFICATIONS: _____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

DATE OF LAST PHYSICAL EXAMINATION (must be within 24 months of first day of camping week): _____

By signing below, you authorize the Camp Nurse to treat your child for any and all injuries or illnesses that arise during their stay at Camp Northfield and for any pre-existing medical conditions.

Signature of Parent/ Guardian

Date

Signature of Licensed Physician

Date