

For Office Use


# Health Examination Form for Children, Youth and Adults Attending Camps FM 12

Dates of Camp Attendance \_\_\_\_\_

**Suggested for resident camp use.**

Developed and approved by the  
**American Camping Association®**  
with the American Academy of Pediatrics

Mail this form to the address below by \_\_\_\_\_ (date)



**CAMP CAROLWOOD**  
1181 Camp Carolwood Rd.  
Lenoir, NC 28645

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying

appropriate care. Health exam must be completed by approved licensed medical personnel at least every two years.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street address City State Zip

Social Security number of participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

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

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

## Health Care Recommendations by Licensed Medical Personnel

I examined the above camp participant on \_\_\_\_\_. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions \_\_\_\_\_

## Recommendations and Restrictions at Camp

Treatment to be continued at camp \_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

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

Known allergies \_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

Additional information for health care staff at the camp \_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

Year

Cabin or Group

Name