2024 Chinese Cultural School Youth Summer Camp
HEALTH FORM

Submit it online or email it to hsia@bellsouth.net

This form is to be completed by parent or guardian and the physician at the time of the examination.

Name: ____
Last First M.I.

BIRTH DATE: ____________ SEX: ________ AGE: _______

PARENT OR GUARDIAN: ______________________________

HOME ADDRESS: ____
Street City State Zip

WORK PHONE: _________________ CELL PHONE: ________________ HOME PHONE: ________________

IF NOT AVAIABLE IN AN EMERGENCY, NOTIFY:

1. NAME: _________________________ WORK PHONE: _______________ CELL PHONE: _______________

____ HOME PHONE: _______________
Street City State Zip

2. NAME: _________________________ WORK PHONE: _______________ CELL PHONE: _______________

____ HOME PHONE: _______________
Street City State Zip

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infection	____________	Hay Fever	____________	Chickenpox	____________
Rheumatic Fever	____________	Poison Ivy	____________	Measles	____________
Convulsions	____________	Insect Stings	____________	German measles	____________
Diabetes	____________	Allergies (list)	____________	Mumps	____________
Asthma	____________	Mononucleosis (mono)	_______	Other	____________

OPERATIONS OR SERIOUS INJURIES (DATES) ______________________________

CHRONIC OR RECURRING ILLNESS ______________________________

OTHER DISEASES OR DETAILS OF ABOVE______________________________

MEDICAL INSURANCE CARRIER_____________________POLICY NO.________________

SPECIFIC ACTIVITIES TO BE ENCOURAGED? ______________RESTRICTED? ________

IMPORTANT: Please notify the **Chinese Cultural School** if the camper is exposed to any communicable disease during the three weeks prior to camp attendance.

SUGGESTIONS FROM PARENTS: ______________________________

PARENTS AUTHORIZATION: I have reviewed this health history and confirmed that all the information is current and correct. The person herein described has permission to engage in all prescribed camp activities, except as noted by the examining physician and me. I have provided any medications that my children will need to take in the original container with written instructions on when they are to be dispensed. I give permission to the adult in charge of the activity to administer the medicine as needed. In the event I cannot be reached in an **EMERGENCY**, I hereby give permission to the physician or his/her associate appointed by the **Chinese Cultural School**, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above.

Signature: ____________________________ Date: ________________________

IMMUNIZATION HISTORY:

Required immunization must be determined locally. This is a record of basic immunizations and most recent booster doses.

DPT Series__________________ Booster______________________ Tetanus Booster_________________
Polio OPV (Saris) _____________ Booster______________________ Typhoid_______________________
Measles Vaccine (live) ________________________________ Mantoux TB Test________________
German Measles (Rubella) _____________________________ Mumps Vaccine (live) _________________
Small Pox____ Covid Vaccination________________________________

Other State or municipal examinations required for staff (if any)
____

MEDICAL EXAMINATION: To be filled out by licensed physician. This examination should be performed within 12 months of arrival at camp site. Examination is for determining fitness to engage in strenuous activities.

CODE: S – Satisfactory X – Not Satisfactory O – Not Examined

Hgt.__________ Wt._________ B.P.______________ Hgb. Test_________________________

Eyes_______________________ Hernia________________________________
Glasses______________________ Extremities____________________________
Ears_________________________ Posture (Spine) _________________________
Nose________________________ Skin___________________________________
Throat_______________________ Allergy: please specify_____________________________
Teeth_______________________ ____
Heart_______________________
Lungs________________________ General Appraisal_________________________________
Abdomen____________________

(For girls and women)
Has this person menstruated? ________________ If so, is her menstrual history normal? ______________

Special Considerations? ____

Recommendations and restrictions while in camp:

Special Diet____
Medication (Name) ______________________________________ Needed at Camp? ________________
Strenuous Activity____
Other____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Telephone: ____________________________ ____________________________________M.D. ______________________________
Examining Physician Printed Name of Physician

Address: ____

____ Email: ____

Date: ____