**2025 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_