ADULT HEALTH HISTORY RECORD

Please turn in this completed form to the Nurse at the time of the Camp Physical. <u>Bring all current prescription and over-the-counter medications to the Physical. These will be recorded and locked up for use at Camp. Only bring enough medications to last for camp.</u>

Section I. Complete prior to the physical:

Name: (Last, First, Middle)		Date of Birth	Sex:
Street Address:	City:	State & Zip Code:	
Phones: (include area code) Home:	Work:	Cell Phone / Pager:	
Health Insurance Co.:	Contract #:	Plan Code:	
Group #:	Coverage Code:	Enrollee:	
Employer:	Family Dr. Name:	Doctors Phone #:	

History of:	Yes	No	History of:	Yes	No	History of:	Yes	No
Appendicitis			Glasses or Contact Lenses			Pregnancies		
Asthma, Wheezing, Shortness of Breath			Headaches			Rheumatic Fever		
Bleeding Disorder			Heart Trouble			Scarlet Fever		
Chickenpox			Hearing Problem, ear aches			Seizures		
Constipation			Kidney Trouble			Tonsillitis		
Dental Problems			Measles - Regular			Tuberculosis		
Diabetes			German Measles			Urinary Tract Infections		
Ear Infections (recent/chronic)			Mumps			Venereal Disease		
Excema or skin rashes			Muscle or Nerve Disorder			Whooping Cough		
Fainting			Pneumonia			Other:		

ALLERGIES (Food, Drugs, Other):

Operations or injuries:

Current Infectious Disease(s):

IMMUNIZATION	POLIO	MUMPS	DIPHTHERIA	TETANUS	PERTUSSIS	MEASLES	RUBELLA	TB	CHICKEN POX	HEPATITIS B
Date First Completed										
Most Recent Booster										

SECTION II. PHYSICAL EXAMINATION - TO BE COMPLETED BY A LICENSED NURSE:

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

TEMPERATURE: _____ ☐ ORAL ☐ AXILLARY ☐ EAR ☐ TEMPORAL

PULSE: _____ ☐ Regular Rate and Rhythm Other: _____

LUNGS: ☐ Clear to Ascultation Other: _____

THROAT: ☐ Clear Other: _____

LICE NITS ☐ None Noted ☐ Present

I have on this date, examined this person in order to determine physical fitness and/or apparent evidence of communicable disease. In my opinion, the applicant ☐ IS ☐ IS NOT physically and emotionally able to participate in the indicated program.

EXAMINATION DATE:	SIGNATURE OF LICENSED NURSE:
TELEPHONE #:	ADDRESS:

MEDICATIONS PROVIDED FOR CAMP: (To be completed by health professional at time of health screening)

Name	Purpose	Dosage	Frequency	Amount