Sanford Day Camps
Email: info@sanfordcamps.com **Fax: 610-565-4764**

HEALTHCARE APPRAISAL AND RECORD

Both the parent and the doctor must complete this 2-page form:

Name _____ Date of Birth _____ Sex _____ Age ____

Parent or Guardian _____ Best Phone _____

Address _____ Alternate Phone _____

City, State, Zip _____

ALLERGIES

Hay Fever _____
Plant _____
Insect Stings _____
Food _____
Drugs _____

HEALTH CONDITIONS (√-give approx. dates)

Heart Related _____
Convulsions _____
Diabetes _____
Ear Infection _____
Chicken Pox _____
German Measles _____
Measles _____
Asthma _____
Behavior _____
Mumps _____

Surgeries or Serious Injuries (Dates) _____
Chronic or Recurring Illness _____
Other Diseases or Details of Above _____
Any Specific Activities To Be Restricted? _____
Provide two (2) emergency contacts (name and phone):

_____

_____

Specify Hospital of Choice (if no preference, specify NONE): _____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable diseases during the (3) weeks prior to camp attendance.

Parent Authorization This health history is correct so far as I know, and my child named herein has permission to engage in all camp activities on or off premises, except as noted by me or the examining physician on this form. In the event I cannot be reached in an emergency, I hereby give permission to Sanford Camp and medical authorities to transport and medically treat my child.

Parent Signature: _____

MEDICAL EXAMINATION:
The following questionnaire is to be filled out by a licensed physician. This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Immunization History
Required immunizations must be determined locally. This is a record of dates of basic immunizations and recent boosters. A copy of the doctor's immunization records is acceptable.

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DIP Series _____	Booster _____	Tetanus Booster _____
Polio QPV (Sabin) _____	Booster _____	Typhoid _____
Measles Vaccine (live) _____	Tuberculin _____	German Measles (Rubella) _____
Mumps Vaccine _____	Smallpox _____	Other _____

(PLEASE ENTER THE APPROPRIATE CODE ON EACH LINE BELOW)
S – Satisfactory **X** – Not Satisfactory (Explain) **O** – Not Examined **NA** – Not Applicable

Height _____ Weight _____ B.P._____ HGB Test _____ Urine _____

Eyes _____	Extremities _____	Throat _____	Teeth _____
Posture (spine) _____	Lungs _____	Heart _____	Abdomen _____
Ears _____	Skin _____	Hernia _____	Nose _____

General Appraisal Comments: _____

_____

(For Girls)
Has this person menstruated? Yes□ No□ If yes, is her menstrual history normal? Yes□ No□
If not, has she been educated as to what to expect? Yes□ No□
Special Considerations: _____

Recommendations/restrictions while in camp:
Special Diet _____
Special drugs/prescriptions Yes□ No□ If yes, name of drug: _____
Swimming, Diving _____
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.

_____ M.D./D.O./P.A.
Examining Physician

Date: _____

Doctor's Telephone: _____

Doctor's Office Address: _____

City/St/Zip _____