

**THIS FORM MUST BE COMPLETED PRIOR TO ARRIVAL AT CAMP**  
**Please attach a photograph so our nurses can more quickly learn to identify your child.**

**Blue Mountain Cross Country LLC**

**CAMPERS HEALTH EXAMINATION FORM**  
**Developed and approved by**  
**American Camping Association and American Academy of Pediatrics**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

In emergency notify \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

\*\*\*\*\*

**Past Illnesses:** (check - giving approximate dates)

Asthma \_\_\_\_\_ Chickenpox \_\_\_\_\_

Heart Trouble \_\_\_\_\_ Scarlet Fever \_\_\_\_\_

Convulsions \_\_\_\_\_ Diabetes \_\_\_\_\_

Serious Ivy, Oak or Sumac Poisoning \_\_\_\_\_

Operations \_\_\_\_\_

Other Diseases or details of above \_\_\_\_\_

**Immunizations:** (Record Dates of last injection only, Except Polio Vaccine)

DTP \_\_\_\_\_ MMR \_\_\_\_\_ Polio \_\_\_\_\_

Recent Exposure to Contagious Disease \_\_\_\_\_

\* Any restrictions to swimming? \_\_\_\_\_ Diving? \_\_\_\_\_

\* Is camper under any Special Medical or Dietary Regime to be continued \_\_\_\_\_

\*\*\*\*\*

**In case of emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection anesthesia or surgery for my child as named above.**

**Signature** \_\_\_\_\_  
(parent/guardian)

**Each camper is required to be covered by the family's Blue Cross and Shield or other commercial medical policy.**

**Insurance CO.Name&Address** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Policy#** \_\_\_\_\_

**Date of Birth of Insured:** \_\_\_\_\_ **Social Security # of Patient:** \_\_\_\_\_

**PHYSICAL EXAMINATION - To be completed by a Licensed M.D.**

**(Within 1 year prior to camper's arrival at camp )**

Code: ~ . . . Negative  
X . . . Not Satisfactory (Explain)

General Condition  
or Appraisal \_\_\_\_\_

Throat/Tonsils \_\_\_\_\_

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

Blood Pressure \_\_\_\_\_

Heart \_\_\_\_\_

Murmur \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Eyes: Vision \_\_\_\_\_

Ears: Hearing \_\_\_\_\_

Allergy: Animals \_\_\_\_\_

Food \_\_\_\_\_

Drugs \_\_\_\_\_

Other \_\_\_\_\_

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Examining Physician)

\_\_\_\_\_  
(Date of Exam)

Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_