CAMP PINEHURST
MEDICAL HISTORY AND PHYSICAL EXAM FORM

RETURN ***BEFORE*** JUNE 1st TO
CAMP PINEHURST
12 Cider Lane
Nashua, NH 03063

After June 1st
Please mail to:
Camp Pinehurst
23 Curtis Road
Raymond, Maine 04071

NAME____ Social Security Number_________________________
Parent(s) / Guardian(s)____
HOME ADDRESS____CAMPER BIRTHDATE____________
TOWN____STATE________________________ZIP_____________
TELEPHONE # HOME____________________WORK__________________CELL /PAGER___________________

EMERGENCY CONTACTS

NAME______________________________RELATIONSHIP____________________ TEL.#____________________
NAME______________________________RELATIONSHIP_____________________TEL.#____________________

IMMUNIZATION RECORD

Last DT Booster__________ MMR___________
Polio Series completed _________ ChickenPox_______

ALLERGIES

Penicillin______ Other drugs__________
Bee stings_______ (will bring own Epipen) Asthma__________
Ivy / Oak / Sumac Foods______________________

PHYSICIAN STATEMENT: The child is capable of participating in all camp activities unless noted specifically on reverse side.

Written orders for ALL prescription drugs being administered while child attends camp MUST accompany this form. Use additional page if needed.

1.____
2.____
3.____

PHYSICIAN'S SIGNATURE____________________________Printed Name_________________DATE__________

PARENTAL STATEMENT When the camp secures medical attention for my child, I grant permission to Doctors to utilize medical tests and x-rays. In an emergency and I cannot be reached, I authorize doctors to immediately begin proper treatment including injections, anesthesia, and surgery.

SIGNATURE____**Parent / Guardian DATE**___________-
WITNESS____

THE CAMP MUST BE NOTIFIED IF THIS CHILD HAS OR IS EXPOSED TO ANY COMMUNICABLE DISEASE WITHIN THREE WEEKS PRIOR TO ENTERING CAMP!

PHYSICIANS EXAM

HEIGHT ____________ WEIGHT ____________ BLOOD PRESSURE _________________

URINALYSIS ________________ HCT or HGB TEST_______________ TINE____________

ABNORMAL FINDINGS ____-
____

HEALTH BACKGROUND

Circle any that pertain to this child:

Bed wetting Chronic ear infections Frequent strep throat Diabetes

Blood disorders Heart disorders Pollen, dust, mold allergies : injections required?

Eyeglasses Corrective shoes or orthotics Hearing aids Orthodontic appliances

Parent or Physician comments on the above____
____-

CAMPER RESTRICTIONS

Physical____
Dietary____
Medical treatments in progress____

MEDICAL CONTACTS

Pediatrician or family doctor____
Address____TEL#__________________

Dentist____TEL#__________________

Orthodontist____TEL#__________________

Optometrist / Opthamologist____TEL#___________________