Check all items that apply, **past or present,** to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain: ____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐
Convulsions/seizures	☐	☐	Hemophilia	☐	☐			

Explain: ____

List any medications to be taken at camp: ____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: ____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: ____

Immunizations: (give date of last inoculation)

Tetanus toxoid ____	Measles ____	Polio ____
Diphtheria ____	Mumps ____	____
Pertussis ____	Rubella ____	____

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form)

Name ____ Age ____

NOTE TO LICENSED MEDICAL Practitioners*: The person being evaluated will be attending 1 or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the HEALTH HISTORY with the participant for any interim changes. *Explain any "abnormal" evaluations.*

PHYSICAL EXAMINATION (To be filled out by a licensed medical practitioner)

Height ____ Weight ____ BP ____/____ Pulse ____

Lab: Urinalysis (dipstick) ____ Albumin ____ Sugar ____

VISION: Normal ____ Glasses ____ Contacts ____

HEARING: Normal ____ Abnormal ____ Explain ____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary system	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐

Explain: ____

Limitations

Activity restrictions ____

Diet restrictions ____

Signature ____ M.D./D.O./D.C./P.A./R.N.P.* Date ____

Address ____ Phone ____

City, State, ZIP ____

*Examinations conducted by doctors of chiropractic, physician's assistants, or pediatric nurse practitioners will be recognized only in states where they may perform physical examinations for students enrolled in public school systems.

INTERVAL RECORD DATE, TIME, PLACE, ETC.	SCREENING EXAMINATION (Findings, diagnoses, treatment, instructions, disposition, etc.)	BY

A PHOTOCOPY OF THIS FORM IS PERMITTED

NAME ____ TROOP ____ CAMPSITE ____

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