For Office Use

Year

Cabin or Group

Name

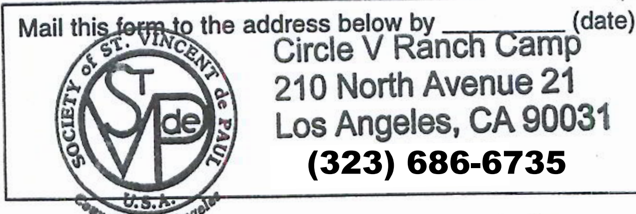
Health Examination Form for Children, Youth and Adults Attending Camps FM 12

Suggested for resident camp use.

Developed and approved by the
American Camping Association®
with the American Academy of Pediatrics

Dates of Camp Attendance ____________

Mail this form to the address below by __________ (date)



Circle V Ranch Camp
210 North Avenue 21
Los Angeles, CA 90031
(323) 686-6735

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health exam must be completed by approved licensed medical personnel at least every two years.

Name ____________ (*Last* / *First* / *Middle*) Birth date ____________ Age at camp ______

Home address ____________ (*Street address* / *City* / *State* / *Zip*)

Social Security number of participant ____________ Gender: ☐ Male ☐ Female

Custodial parent/guardian ____________ Phone ____________

Home address (*if different from above*) ____________ (*Street address* / *City* / *State* / *Zip*)

Business address ____________ (*Street address* / *City* / *State* / *Zip*) Phone ____________

Second parent or guardian or emergency contact ____________

Address ____________ (*Street address* / *City* / *State* / *Zip*) Phone ____________

Business address ____________ Phone ____________

If not available in an emergency, notify ____________

Relationship ____________ Phone ____________

Address ____________ (*Street address* / *City* / *State* / *Zip*)

Health Care Recommendations by Licensed Medical Personnel

I examined the above camp participant on ____________. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP ____________ Weight ____________ Height ____________

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions ____________

Recommendations and Restrictions at Camp

Treatment to be continued at camp ____________

Medications to be administered at camp (name, dosage, frequency) ____________

Any medically-prescribed meal plan or dietary restrictions ____________

Known allergies ____________

Description of any limitation or restriction on camp activities ____________

Additional information for health care staff at the camp ____________

Signature of Licensed Medical Personnel ____________

Printed ____________ Title ____________

Address ____________

Phone ____________ Date ____________

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