

2020 Chinese Cultural School Youth Summer Camp
HEALTH FORM

Return to: Ms. Edith Bell, c/o Chinese Cultural School / Camp, 5816 County Court, Buford, GA 30518

This form is to be completed by parent or guardian and the physician at the time of the examination.

Name: _____
Last First M.I.

BIRTH DATE: _____ SEX: _____ AGE: _____

PARENT OR GUARDIAN: _____

HOME ADDRESS: _____
Street City State Zip

WORK PHONE: _____ CELL PHONE: _____ HOME PHONE: _____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:

1. NAME: _____ WORK PHONE: _____ CELL PHONE: _____

_____ HOME PHONE: _____
Street City State Zip

2. NAME: _____ WORK PHONE: _____ CELL PHONE: _____

_____ HOME PHONE: _____
Street City State Zip

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infection	_____	Hay Fever	_____	Chickenpox	_____
Rheumatic Fever	_____	Poison Ivy	_____	Measles	_____
Convulsions	_____	Insect Stings	_____	German measles	_____
Diabetes	_____	Allergies (list)	_____	Mumps	_____
Asthma	_____	Mononucleosis (mono)	_____	Other	_____

OPERATIONS OR SERIOUS INJURIES (DATES) _____

CHRONIC OR RECURRING ILLNESS _____

OTHER DISEASES OR DETAILS OF ABOVE _____

MEDICAL INSURANCE CARRIER _____ POLICY NO. _____

SPECIFIC ACTIVITIES TO BE ENCOURAGED? _____ RESTRICTED? _____

IMPORTANT: Please notify the **Chinese Cultural School** if the camper is exposed to any communicable disease during the three weeks prior to camp attendance.

SUGGESTIONS FROM PARENTS: _____

PARENTS AUTHORIZATION: I have reviewed this health history and confirmed that all the information is current and correct. The person herein described has permission to engage in all prescribed camp activities, except as noted by the examining physician and me. I have provided any medications that my children will need to take in the original container with written instructions on when they are to be dispensed. I give permission to the adult in charge of the activity to administer the medicine as needed. In the event I cannot be reached in an **EMERGENCY**, I hereby give permission to the physician or his/her associate appointed by the **Chinese Cultural School**, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above.

Signature: _____ Date: _____

IMMUNIZATION HISTORY:

Required immunization must be determined locally. This is a record of basic immunizations and most recent booster doses.

DPT Series _____	Booster _____	Tetanus Booster _____
Polio OPV (Saris) _____	Booster _____	Typhoid _____
Measles Vaccine (live) _____		Mantoux TB Test _____
German Measles (Rubella) _____		Mumps Vaccine (live) _____
Small Pox _____		Other _____

Other State or municipal examinations required for staff (if any) _____

MEDICAL EXAMINATION: To be filled out by licensed physician. This examination should be performed within 12 months of arrival at camp site. Examination is for determining fitness to engage in strenuous activities.

CODE: S – Satisfactory X – Not Satisfactory O – Not Examined

Hgt. _____	Wt. _____	B.P. _____	Hgb. Test _____	Urianalysis _____
Eyes _____			Hernia _____	
Glasses _____			Extremities _____	
Ears _____			Posture (Spine) _____	
Nose _____			Skin _____	
Throat _____			Allergy: please specify _____	
Teeth _____			_____	
Heart _____				
Lungs _____			General Appraisal _____	
Abdomen _____				

(For girls and women)

Has this person menstruated? _____ If so, is her menstrual history normal? _____

Special Considerations? _____

Recommendations and restrictions while in camp:

Special Diet _____

Medication (Name) _____ is parent sending it? _____

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.

Telephone: _____ M.D. _____
Examining Physician Printed Name of Physician

Address: _____

_____ Email: _____

Date: _____