

CAMPER HEALTH EXAMINATION FORM FOR BOYS & GIRLS

****2025****

DEVELOPED and APPROVED BY
AMERICAN CAMPING ASSOCIATION and AMERICAN ACADEMY OF PEDIATRICS
REQUIRED BY New Jersey STATE LAW

FROGBRIDGE DAY CAMP

7 Yellow Meeting House Road
Millstone Township, NJ 08510
Phone: (609) 208-9050 or (732) 786-9050
Fax (609) 208-9052

(This side to be filled in by parent/guardian and checked with physician at time of examination)

Name _____ Birth Date _____ Age _____
Parent or Guardian _____ Phone _____
Home Address _____
In emergency notify _____ Phone _____
Relationship _____
Address _____

HEALTH HISTORY: (Check - giving approximate dates)

Frequent Colds _____	Kidney Trouble _____	Chicken Pox _____
Frequent Sore Throats _____	Bed Wetting _____	Measles _____
Sinusitis _____	Heart Trouble _____	German Measles _____
Abscessed Ears _____	Convulsions _____	Mumps _____
Bronchitis _____	Athlete's Foot _____	Poliomyelitis _____
Fainting _____	Sleep Walking _____	Whooping Cough _____
Stomach Upsets _____		Rheumatic Fever _____
Constipation _____		Tuberculosis _____
Serious Ivy, Oak or Sumac Poisoning _____		Diabetes _____
Operations or Serious Injuries _____		
General Appraisal _____		
Has girl menstruated? _____	Has girl been told about menstruation? _____	

Allergic Reactions:
Bee Sting _____ Penicillin _____ Other Drugs _____

Please list any medications (prescription and/or over the counter) your child is currently taking
Name/Dosage/when given: _____

Any specific activities to be encouraged? _____
restricted? _____

Does this child have any mental, physical or emotional problems _____ If yes, describe: _____

IMPORTANT: Please notify the camp if this child is exposed to any communicable disease during the three weeks prior to camp attendance.

Suggestions from parents regarding health concerns **only:**

IN CASE OF EMERGENCY I understand every effort will be made to contact parents or guardian of campers. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia and/or surgery for my child, as named above. This form may be photocopied for use out of camp.

Signature of parent/guardian _____ **Date** _____

Parent/Guardian: Complete this side and sign above.

Physician: Complete reverse side.

This form must be returned to camp office by May 1st to complete enrollment.

Camper's Name: _____

D.O.B.: _____

PHYSICAL EXAMINATION

To be filled out and signed below by a Licensed Physician.
(Changes must be made **three months** prior to camper's arrival at camp.)

Code: S- Satisfactory

NS- Not Satisfactory (explain)

Hgt. _____	B.P. _____	Urinalysis test done: _____
Wt. _____	Hgb. test done: _____	
Eyes _____	Extremities _____	
Contacts/glasses _____	Posture (spine) _____	
Ears _____	Skin _____	
Nose _____	Allergy - Please specify _____	
Throat _____	Emotional Stability __ Much __ Some __ Little __ None	
Teeth _____	Maturity __ Much __ Some __ Little __ None	
Heart _____	Any Personal Problems __ Much __ Some __ Little __ None	
Lungs _____	Any Behavior Problems: Explain _____	
Abdomen _____	Any Learning Problems: Explain _____	
Genitalia _____	Menstrual History _____	
Hernia _____	General Appraisal _____	

Recommendations and restrictions (diet, medicine, swimming, diving, etc.) _____

May this child take an aspirin substitute? If so, specify adult or child substitute and dosage. _____

Immunizations:

D.P.T. Series _____	Booster _____	date _____
Tetanus _____	Booster _____	date _____
Polio Series _____	Booster _____	date _____
Measles _____	Booster _____	date _____
Mumps _____	Booster _____	date _____
Rubella _____	Booster _____	date _____
Haemphilis (Hib) _____	Booster _____	date _____
Varicella _____		
Hepatitis B _____		

Signature Examining Physician _____ Date: _____

Address _____

Telephone _____