

# Ukrainian Dance Workshop/Camp HEALTH EXAMINATION FORM

for Children, Youth and Adults  
Developed by  
American Camping Assoc. Inc.  
In consultation with  
The American Medical Assoc./American Academy of Pediatrics

LAST NAME _____
FIRST NAME _____
AGE _____ Birthdate _____
BUNK _____
SR. COUNSELOR _____

FOR CAMP USE ONLY.

## FILED IN BY PARENT or ADULT CAMPER

NAME \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Gaurdian \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Work Phone(s) \_\_\_\_\_

Business Address \_\_\_\_\_ Cell Phone(s) \_\_\_\_\_

### If not available in an emergency notify:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell \_\_\_\_\_

### MEDICAL CARE COVERAGE

In signing this Medical Care Coverage I certify that my child is in good health, and has my permission to engage in all prescribed camp activities, except as noted by me and the examining physician.  
I give permission to the physician selected by the Camp Director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anaesthesia and/or surgery for my child as named above.

Signature of Parent of Legal Gaurdian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

### FAMILY MEDICAL/HOSPITAL INSURANCE

CARRIER \_\_\_\_\_ POLICY OR GROUP# \_\_\_\_\_

UNDER WHOSE NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_

Name of Family Physician (if other than examining physician) \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

### HEALTH HISTORY (If normal mark N, or give approximate dates of problem.)

Frequent ear infections _____	<b>Operations or Serious Injury</b>
Heart defect/disease _____	_____
Convulsions _____	_____
Diabetes _____	<b>Chronic or Recurring Illness</b>
Bleeding/Clotting disorders _____	_____
<b>Allergies</b>	<b>Other Diseases</b>
Hay Fever _____	_____
Ivy Poisoning etc. _____	<b>Previous or chronic injuries that may</b>
Insect Stings _____	<b>impair taking part in daily dance</b>
Penicillin _____	<b>classes and rehearsals:</b>
Other Drugs _____	_____
<b>Diseases</b>	_____
Chicken Pox _____	_____
Measles _____	_____
German Measles _____	_____
Mumps _____	_____
Asthma _____	_____

### MEDICATION

If your child is currently on any prescribed medications, or carries medication for asthma or allergies, please list below with indications. All medications must be labeled and left in care of Camp Nurse or Commandantka. If child needs to carry these on person, please enclose a physicians note explaining this.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMPORTANT: Please notify the camp if this camper is exposed to any communicable diseases during the three weeks prior to camp attendance.**

**TO BE COMPLETED BY PHYSICIAN.**

This examination should be performed within 12 months of arrival at camp.  
Examination for some other purpose within this period is acceptable.

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please record the date (month/year) of basic immunizations and most recent booster doses.

Vaccines	Date of Basic Immunization	Date of Last Booster
Diphtheria/Pertussis/Tetanus DPT or Tetanus/Diphtheria TD or Tetanus		
Poliomyelitis		
Measles		
Mumps		
Rubella		
Cold/Flu		

**MEDICAL EXAMINATION**

Examination is for determining fitness to engage in strenuous physical activities.

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

Hct. or Hgb. Test \_\_\_\_\_ Urinalysis \_\_\_\_\_

If normal mark 'N' - If any abnormalities, please state nature of such.

Eyes _____	Lungs _____	Speech _____
Glasses _____	Abdomen _____	Hearing _____
Lenses _____	Hernia _____	Nutrition _____
Ears _____	Spine _____	Cognition _____
Nose _____	Skin _____	Menstruation _____
Throat _____	Orthopedic: _____	Other _____
Heart _____	Structural _____	
Genitalia _____	Posture _____	
	Feet _____	

Please list ALLERGIES, EXISTING MEDICAL CONDITIONS, RESTRICTIONS, LIMITATIONS, SPECIAL NEEDS or DIETS, MEDICATION and indications, or other concerns such as bed wetting, sleep walking, etc.

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**I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in Dance Camp/Worskhop activities, except as noted above.**

Examining Physician \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_