

CAMP NEW DAWN II HEALTH EXAMINATION FORM

RETURN TO: Butman Camp Registrar
158 CR 674
Merkel, TX 79536

Please have parent/guardian and physician complete appropriate sections of this form **in full** before mailing. The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Camper Name: _____ Date: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

***This section must be filled out before form is considered complete.**

- Is camper on a special diet? ___ Yes ___ No Explain _____
- Is camper on any special medicine? ___ Yes ___ No Explain _____
- Is camper on any new medication? ___ Yes ___ No Explain _____
- Is medicine being sent by parent/guardian? ___ Yes ___ No Explain _____
- Restrictions on swimming, diving? ___ Yes ___ No Explain _____
- Restrictions on strenuous activity? ___ Yes ___ No Explain _____
- Is camper able to dress self? ___ Yes ___ No Explain _____
- Is camper able to sleep in an upper bunk? ___ Yes ___ No Explain _____
- Is camper able to talk? ___ Yes ___ No Explain _____
- Does camper walk well? ___ Yes ___ No Explain _____
- Is camper an early riser? ___ Yes ___ No Explain _____
- Does camper wet the bed? ___ Yes ___ No Explain _____
- Does camper smoke or chew tobacco? ___ Yes ___ No Explain _____
- Is camper able to read? ___ Yes ___ No Explain _____
- Does camper have incontinence problems? ___ Yes ___ No Explain _____
- Is camper a sleepwalker? ___ Yes ___ No Explain _____
- Does camper wear protective garments (i.e. Depends) ___ Yes ___ No Explain _____

Campers T-Shirt Size S M L XL XXL

Other _____

	Totally Independent	Partially Independent	Dependent
Brush Teeth			
Bathing			
Dressing			
Eating			
Toilet Usage			

PARENT/GUARDIAN AUTHORIZATION: This health history is correct so far as I know and the person herein described has my permission to engage in all prescribed camp activities, except as noted by me and the examining physician. **In the event that I cannot be reached in an EMERGENCY**, I hereby give permission to the physician, selected by the camp director, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Parent/Guardian Signature: _____ **Date:** _____

MEDICAL EXAMINATION
To be filled out by licensed physician

This examination should be performed within 12 months before arrival at camp. **You may attach a current physical (if it occurred in the last 12 months) as long as it contains the same information as below.** Examinations are necessary for determining fitness/ability to engage in all activities.

CODE: S – Satisfactory U - Unsatisfactory (Explain) O - Not Examined

Height: _____ Weight: _____ B.P.: _____ Hgb. Test: _____ Urinalysis: _____

Eyes _____ Extremities _____

Glasses _____ Posture (spine) _____

Ears _____ Skin _____

Nose _____ Allergy - Please specify: _____

Throat _____

Teeth _____

Heart _____

Lungs _____ General Appraisal: _____

Abdomen _____

Hernia _____

* (For girls and women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

Comments: _____

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.

Physician Signature: _____ **Date:** _____

Address: _____ **Telephone:** () _____

Camper's Name: _____ **Date Examined:** _____ **Cabin #** _____ **Year:** _____

