



HEALTH EXAMINATION FORM

PLEASE MAIL BACK TO:

InspireWorks Enrichment
481 North Rd.
Westfield, MA 01085

This side to be filled in by parent and checked with physician at time of examination.

Name _____ Birth Date _____ Sex _____ Age _____
Last First Initial

Parent/Guardian _____ Phone (____) _____

Home Address _____
Street & Number City State Zip

If not available in an emergency notify:

1. _____ Phone (____) _____
Name

Street & Number City State Zip

2. _____ Phone (____) _____
Name

Street & Number City State Zip

HEALTH HISTORY: Check –giving approximate dates)

	Allergies	Diseases
Ear Infections _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Ivy Poisoning, etc _____	Measles _____
Convulsions _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Asthma _____

Operations or Serious Injuries (Dates) _____

Chronic or Recurring Illness _____

Other Diseases or Details of Above _____

Any specific activities to be encouraged? _____
restricted? _____

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

PARENTS AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician.

In the even 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 my child as named above.

Signature _____

Date _____



HEALTH EXAMINATION FORM (continued)



****The following sections are to be filled out by a licensed physician****

IMMUNIZATION HISTORY

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

DTP Series _____ booster _____ Tetanus Booster _____

Polio OPV (Sabin) _____ booster _____ Typhoid _____

Measles Vaccine (live) _____ Tuberculin Test _____

German Measles (Rubella) _____ Mumps Vaccine (live) _____

Other _____

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

MEDICAL EXAMINATION

This examination should be performed within the last 18 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

- Code:** **S** Satisfactory
 X Not Satisfactory (explain)
 O Not Examined

Date of Physical Examination: _____

Hgt. _____ Wt. _____ B.P. _____ Hgb Test _____ Urinalysis _____

Eyes _____	Extremities _____
glasses _____	Posture (Spine) _____
Ears _____	Skin _____
Nose _____	Allergy:
Throat _____	Please Specify
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: _____

Recommendations and restrictions while in camp.

Special Diet/Food allergies _____

Special Medicine (name it) _____ Is parent sending it? _____

Swimming, diving _____

Strenuous activity _____

Other _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he is physically able to engage in camp activities, except as noted above.

Examining Physician M.D.

Phone (____) _____

Address _____

Date _____

(OVER)