

# Expeditions Unlimited

## CAMP HEALTH EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS

Developed by the American Camping Association in consultation with The American Medical Association and the American Academy of Pediatrics

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_ M: \_\_\_ F: \_\_\_ Age: \_\_\_\_\_  
Last First M. Init.

Name of Parents/Guardians (or spouse): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Email Address: \_\_\_\_\_

Check here if you do not wish to receive further mailings from Expeditions Unlimited.

If not available in an emergency please notify:

1. \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name Relationship
2. \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name Relationship
3. \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name Relationship

Check all that apply, giving approximate dates

Health History	Allergies	Diseases	Date
____ Frequent Ear Infections	____ Hay Fever	____ Chicken Pox	_____
____ Heart Defect/Disease	____ Poison Ivy, etc.	____ Measles	_____
____ Convulsions	____ Insect Stings	____ German Measles	_____
____ Diabetes	____ Penicillin	____ Mumps	_____
____ Bleeding/Clotting Disorders	____ Other Drugs	____ Asthma	_____

Allergies (describe reactions/treatment): \_\_\_\_\_

Operations or serious injuries and dates: \_\_\_\_\_

Chronic or recurring illnesses: \_\_\_\_\_

Dentist/Orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Medical/Health Insurance Company: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

**IMPORTANT:** Please notify Expeditions Unlimited if this individual is exposed to any communicable disease during the three weeks prior to attending the trip.

Additional Notes/Comments: \_\_\_\_\_

### IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

**Parental Authorization.** This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Expeditions Unlimited staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Expeditions Unlimited staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature: \_\_\_\_\_ Date: \_\_\_\_\_