easterseals
Camp Sno-Mo

Personal Health and Medical Record

1. IDENTIFICATION

2. Age: _____ Sex:_____ D.O.B_____ Name:_____

Address:_____ Last Name First Name Initial

City & State: _____ Zip: _____

Health/Accident Insurance _____ Policy No. _____

IN AN EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Home Address:_____ City & State: _____ Zip Code_____

Phone: _____ Business Phone: _____ Personal Phone _____

2.EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

- ☐ Allergy to a medicine, food, plant, animal, or insect toxin
- ☐ Any condition that may require special care, medication, or diet

- ☐ Asthma
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Bleeding Disorders
- ☐ Convulsions
- ☐ Fainting Spells

Please explain any of the above checked in the comments section on page 3.

3.IMMUNIZATION

Immunization	Last Year Given
Diptheria	_____
Tetanus	_____
Polio	_____

Has Had -	Vaccination	Disease
Measles	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Pertussis	☐	☐
Chicken Pox	☐	☐

4. PHYSICIAN'S EVALUATION AND ADVICE

Approved for participation in:

- ☐ Hiking and Camping
- ☐ Water Activities
- ☐ Competitive sports
- ☐ All Activities

Specific exceptions:_____

Recommendations: (explain any restrictions OR limitations):_____

_____

_____

5 MEDICAL HISTORY

Date of most recent complete physical examination (month and year) _____/_____

Are you aware of any current health problems? yes no

Now under medical care or taking medicines? yes no

Has there been any surgery, illness, allergy, or change in health status since last complete physical examination? yes no

Give dates and full details below for any "yes" answer.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF:

			Year	Details
Serious illness	No	Yes	_____	
Serious injury	No	Yes	_____	
Deformity	No	Yes	_____	
Surgery	No	Yes	_____	
Skin, Glands	No	Yes	_____	
Ears, Eyes	No	Yes	_____	
Nose, Sinus	No	Yes	_____	
Teeth, Tonsils	No	Yes	_____	
Dentures	No	Yes	_____	
Bridge	No	Yes	_____	
Chest, Lungs	No	Yes	_____	
Heart	No	Yes	_____	
Murmur	No	Yes	_____	
Rheumatic fever	No	Yes	_____	
Stomach, Bowels	No	Yes	_____	
Appendicitis	No	Yes	_____	
Kidneys or Urine	No	Yes	_____	
Albumin	No	Yes	_____	
Sugar	No	Yes	_____	
Infection	No	Yes	_____	
Bed Wetting	No	Yes	_____	
Menstrual Problems	No	Yes	_____	
Hernia (rupture)	No	Yes	_____	
Back Limbs Joints	No	Yes	_____	
Sleep walking	No	Yes	_____	
Nervous conditions	No	Yes	_____	
Other (Explanation)	No	Yes	_____	

6. HEALTH EXAMINATION

Physician:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VT) before exam.
- Review immunizations.
- After completing section 6, summarize any restrictions and/or recommendations in section 2 and 5 below in comments, and sign.

	VISION:	HEARING:
DATE: _____	Normal:_____	Normal:_____
Ht. _____Wt. _____	Glasses:_____	Abnormal:____
B.P. _____/____ Pulse_____	Contacts_____	

LABORATORY: Urinalysis (Dip stick)

Albumin _____ Sugar _____

Check box if normal, circle if abnormal and give details below:

O Growth, development	O Teeth, tonsils	O Genitourinary
O Skin, glands, hair	O Respiratory	O Skeletomuscular
O Head, neck, thyroid	O Cardiovascular	O Neuropsychiatric
O Eyes, ears, nose	O Abdomen, hernia, rings	O Other (specify)

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signed: _____ Date_____

*(Physician licensed to practice medicines)

*Examinations conducted by doctors of osteopathy, doctors of chiropractic, or pediatric nurse practitioners will be recognized in states where they may perform physical examinations to students enrolled in public school systems