



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

EXPLAIN: _____

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): _____

3. IMMUNIZATION

Immunization	Last Year Given
Diphtheria	_____
Tetanus	_____
Polio	_____

Has Had -	Vaccination	Disease
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>

6a 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	_____
Murmor	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	_____
Mesnstal 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 above, and sign.

DATE: _____
 Ht. _____ Wt. _____
 B.P. ____/____ Pulse _____

VISION: HEARING:
 Normal:____ Normal:____
 Glasses:____ Abnormal:____
 Contacts _____

LABORATORY: Urinalysis (Dip stick)

Albumin _____ Sugar _____

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

- | | | |
|---|--|--|
| <input type="radio"/> Growth, development | <input type="radio"/> Teeth, tonsils | <input type="radio"/> Genitourinary |
| <input type="radio"/> Skin, glands, hair | <input type="radio"/> Respiratory | <input type="radio"/> Skeletomuscular |
| <input type="radio"/> Head, neck, thyroid | <input type="radio"/> Cardiovascular | <input type="radio"/> Neuropsychiatric |
| <input type="radio"/> Eyes, ears, nose | <input type="radio"/> Abdomen, hernia, rings | <input type="radio"/> 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