Camp AmeriKids, Inc.
88 Hamilton Avenue • Stamford, CT 06902
Phone (203) 658-9500 • Fax (203) 658-9615

STAFF HEALTH FORM

This form must be filled out in its entirety and returned to Camp AmeriKids prior to the start of camp.

GENERAL INFORMATION

Name: _____ Male □ Female □

Date of Birth: _____ Age: _____

Address: _____

_____

Phone: _____ Alternate Phone: _____

**** EMERGENCY CONTACT ****

Name: _____ Relation: _____

Phone: _____ Alternate Phone: _____

PAST MEDICAL HISTORY: (PLEASE ANSWER ALL QUESTIONS)

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension	
		Heart Disease (CHF, CAD, MI)	
		Heart Defects/Murmur	
		Seizures	
		Stroke/TIA	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Bleeding/Clotting Disorder	
		Fainting spells	
		Thyroid Disease	
		Kidney Disease	
		GI problems (abdominal, digestive)	
		Infectious Disease (HIV, Hepatitis, etc)	
		Sickle cell disease	
		Sleep disorder (sleep apnea)	
		Learning disorder (ADHD, ADD)	
		Psychiatric/psychological disorder	
		Menstrual problems (female only)	
		Other	

PHYSICIAN'S PHYSICAL EXAM FORM CONTINUED:

Past Surgical History: (Please list)

_____

_____

Have you been hospitalized in the past 5 years? If so, when & why: _____

_____

Current Medications: _____

Drug Allergies: _____

IMMUNIZATION DATES

Mandatory: Date of immunization or blood test indicating immunity is required! You may attach laboratory results indicating Measles/Mumps/Rubella immunity. (Please note, if you were born before 1957 you are considered immune and do not need to provide a date or blood test.)

* Measles/Mumps/Rubella _____

Strongly Recommended

DPT/dT _____

PPD _____

Hepatitis B _____

Chickenpox vaccine _____
(or history of Chickenpox)

PHYSICAL EXAMINATION -- To be completed by a physician

(1) Satisfactory (2) Not Satisfactory (3) Not Examined

Height: _____ **Weight:** _____ **BP** _____ **HR**_____

Eyes: _____ **Glasses:** _____ **Contacts:** _____

Ears: _____ **Hearing:** _____ **Right:** _____ **Left:** _____

Heart: _____ **Lungs:** _____ **Abdomen:** _____ **Hernia:** _____

Extremities:_____ **Skeletal:** _____ **Skin**_____

Restrictions: _____

Recommendation: _____

The above named person is in satisfactory condition and may engage in all activities except as noted. I have found this person to be physically and emotionally healthy.

Date: _____ **Examining Physician:** _____

Telephone: _____ **Print Name:** _____

State License In: _____ **License Number:** _____

Address: _____

_____

PLEASE RETURN TO:
Camp AmeriKids
88 Hamilton Avenue – Stamford, CT 06902
Fax (203) 658-9615