

# Summer Fit CAMP

www.summerfitcamp.org

## MEDICAL HISTORY FORM

### CAMPER INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE	DATE OF BIRTH		GRADE	

### PARENT/GUARDIAN SECTION

*To be completed by the parent*

	YES	NO		YES	NO
Any past injuries?			Presently taking any medications?		
Fainting or dizziness while exercising?			History of head injury?		
Allergies			Significant past illness?		
Asthma?			Orthodontia (braces)		
Wears glasses/contact lenses?			Any ongoing medical problems?		
Past surgical procedures?			Seizures?		
Any hospitalization?			Bone/joint problems?		
Last tetanus (date):					

COMMENTS ON ANY YES:

PARENT/GUARDIAN SIGNATURE		DATE
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### PHYSICIAN'S SECTION

*To be completed by the physician only*

HEIGHT:		BLOOD PRESSURE:		
WEIGHT:		PULSE/HEART RATE:		
	Normal	Comments	Normal	Comments
General Condition			Gastrointestinal	
Skin			Lungs	
Ears			Genito-Urinary	
Eyes			Neurological	
Nose			Musculoskeletal	
Throat			Spinal	
Mouth/Dental			Nutritional Status	
Cardiovascular			Mental Health	

ADDITIONAL COMMENTS:

I approve the above named child to attend Summer Fit CAMP (circle one)			YES	NO
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PHYSICIAN SIGNATURE		Date
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PRINT NAME	TELEPHONE
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