

# Elim Community Church

15 Centre St □ Bath, Me 04530 207-443-2663 fax 443-4282

## Personal Information:

Full name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_ Age: \_\_\_\_\_

**A Sports/Camp physical examination must be completed within 1 year of the start date of camp, August 2010. Date of physical examination: \_\_\_\_\_**

**Health History- Do not leave any line blank, please. If not applicable, write none or N/A.**

Nose bleeds  Yes  No ADD/ADHD  Yes  No  
Seizures  Yes  No Type: \_\_\_\_\_  
Diabetes  Yes  No  
How controlled?  Insulin  Oral Hypoglycemic  Diet

## Allergies to (please be Specific)

Medications: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Environmental: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Food: \_\_\_\_\_ Reaction: \_\_\_\_\_

Migraines  Yes Treatment: \_\_\_\_\_

Asthma  Yes  No Inhalers  Yes  No

Types of Inhalers used and when: \_\_\_\_\_

Hearing Dis.  Yes  No Hearing Aids  Yes  No  
Visual Dis.  Yes  No Correct with  Glasses  Contact Lenses  Other

## Health Problems

Bone/Joint  Yes  No Stomach  Yes  No  
Heart  Yes  No Kidney  Yes  No  
Lungs  Yes  No Bowel  Yes  No  
Blood pressure  Yes  No Other: \_\_\_\_\_  
Activity Restrict.  Yes  No Reason: \_\_\_\_\_

## Authorization for Treatment

***To my knowledge, the information contained in this health history form is correct and the person herein has permission to engage in all prescribed activities, except as noted. I hereby give permission to the medical personal, selected by the camp director, to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. I hereby give permission to the physician selected by the Pastor to secure and administer treatment, including hospitalization for the person named above. The completed form may be photocopied for trips out of camp.***

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**Physicians Statement of Examination**

Elim Community Church requires all Campers to have a **Sports/Camp physical** within **one year** of the start date of camp!

**Patients Name:** \_\_\_\_\_

**Type of Physical exam performed:** \_\_\_\_\_

**Date of exam:** \_\_\_\_\_

Special Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Treatment given: \_\_\_\_\_

Physical Handicaps, Disorders, Diseases: \_\_\_\_\_

Restricted Activities: \_\_\_\_\_

Reasons: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_ other: \_\_\_\_\_

\_\_\_\_\_

**The Camper will be participating in sports and (heavy lifting) work projects...**

**FEMALE ONLY**

Has the Camper menstruated?     Yes     No

If yes, is her history normal?     Yes     No

**Special considerations:** \_\_\_\_\_

Physicians Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_