Camp WAMP at Deer Lake
Health Examination Form

Mail to:
Stephen J Wampler
941 Orange Ave #440
Coronado, CA 92118
800-381-6891

_____
Name

_____
Name of Camp and Session Dates

This Health Examination Form for Camp must be completed by the parent/guardian & physician at the time of examination and must be received by the Camp Registrar no later than 30 days prior to the camp session. There will be no exceptions. ***A physician must personally examine all campers within 1 year of camp attendance date.

Is camper covered by medical insurance? Yes ☐ No ☐

Name of insurance company: _____

Insurance plan number: _____
*** Attach a photocopy (front & back) of all current Insurance card(s) & prescription cards. * ***

Health History: (Check and give appropriate dates, if known)

Asthma _____ Diphtheria_____ Rheumatic Fever_____
Arthritis_____ German Measles_____ Scarlet Fever _____
Chicken Pox_____ Measles_____ Typhoid_____
Diabetes_____ Mumps_____ Whooping Cough_____
Other_____

Immunization History: Record dates of last injection. (If unknown, write unknown or up-to-date.)

DPT Series_____ Smallpox_____
Booster_____ Tetanus Booster_____
Polio OPV (Sabin)_____ Typhoid_____
Booster_____ Tuberculin Test_____
Measles Vaccine (live) _____ Mumps Vaccine (live) _____
German Measles (Rubella)_____ Other_____

PLEASE NOTIFY US IF CAMPER IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS IMMEDIATELY PRIOR TO CAMP ATTENDANCE.

MEDICAL EXAMINATION (Must be completed by physician.)

Diagnosis: _____

Significant Health History: _____

_____

DOB: _____ **Age:**_____ **Height:** _____ **Weight:** _____

Temp: _____ **HR:** _____ **BP**: _____ **RR:** _____

Allergies (Drug): _____

Allergies (Environmental) : _____

Special Diet: _____

IS CAMPER ON MEDICATION? YES ☐ NO ☐

Name of drug(s):_____

_____

_____

*** Camper is required to bring ample supply of all medications, with prescriptions to camp. All medicines MUST BE prescribed and in their original containers (including all vitamins and herbs) and will be administered according to the doctor's written directions. If there is no prescription the medicine will not be administered by camp nurse.**

Operations or serious injuries (dates & details): _____

_____

_____

Chronic of recurring illnesses: _____

_____

Any pressure sores of significant bruises: _____

_____

Are there any other recommendations or special instructions regarding Camper's activity limitations? (Activities include horseback riding.) _____

_____

I have examined _____ and reviewed his/her Health History. *(Camper's Name)*

In my opinion this Camper is physically able to engage in camp activities, except as noted.
I have attached prescriptions for the Camper as needed.

EXAMINING PHYSICIAN _____

(Please type or print name)

_____

Street City State Zip

Telephone: (____)_____

_____

Signature of Examining Physician **Date**

THIS FORM MUST BE SIGNED AND DATED BY A PHYSICIAN
(within 1 year of camp attendance date)
AND RECEIVED BY CAMP NO LATER THAN
30 DAYS BEFORE SESSION BEGINS.
*****Complete the form in its entirety.****