

- Camper
- Staff

**FORM F – RETURN WITH FORMS A, B, C, D, E**

**MEDICAL EVALUATION**

**MEDICAL PRACTITIONER MUST COMPLETE AND SIGN**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Guardian \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Date of Arrival at Camp: \_\_\_\_\_ Departure Date: \_\_\_\_\_

**Date of Exam** \_\_\_\_\_

\_\_\_\_\_ **May participate in all camp activities.**

\_\_\_\_\_ **May participate except for:** \_\_\_\_\_

**Medical information pertinent to routine care and emergencies:** \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunizations Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus			TB Test		Result:

**Comments:** \_\_\_\_\_

**Health History: (Check any that apply)**

- |                             |                               |                          |                     |
|-----------------------------|-------------------------------|--------------------------|---------------------|
| _____ Epilepsy or seizures  | _____ Frequent ear infections | _____ Menstrual problems | _____ Asthma        |
| _____ Frequent sore throats | _____ Headaches               | _____ Bed wetting        | _____ Heart Disease |
| _____ Back pain or strain   | _____ Alcohol/drug addiction  | _____ Diabetes           | _____ Eye Glasses   |
| _____ Heart Disease         | OTHER: _____                  |                          |                     |

**Pertinent past medical treatment:** \_\_\_\_\_

**ALLERGIES**

**Medication Allergies**

**Describe reaction and management of reaction**

\_\_\_\_\_  
\_\_\_\_\_

**Food Allergies**

\_\_\_\_\_  
\_\_\_\_\_

**Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.)**

**I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.**

\_\_\_\_\_, M.D.

Examining Physician

Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

Return to: Windham-Tolland 4-H Camp, 326 Taft Pond Road, Pomfret Center, CT 06259