

# SLOVENSKI CAMPS HEALTH FORM

A copy of a camper's school physical, **complete with immunization history and doctor's signature**, maybe substituted in lieu of this form if the physical was completed with 12 months of the camp start date.

Camper's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last Name) (First Name)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Medical History (please check for "yes")

German Measles  Measles  Mumps  Scarlet Fever  Chicken Pox   
Diabetes  Pneumonia  Other: \_\_\_\_\_

## Immunization History

Mo./Yr.  
Small Pox Vaccine \_\_\_\_\_  
Diphtheria \_\_\_\_\_  
Tetanus Toxoid \_\_\_\_\_  
Polio Vaccine \_\_\_\_\_  
Tuberculin Test \_\_\_\_\_  
Measles \_\_\_\_\_

## Allergy History

	Yes	No
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>

## Drug Reactions

	Yes	No
Sulpha	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
Type _____		
_____		

If medication will be taken during camp, indicate name of drug and dosage:

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

Please list any pertinent medical information we should have regarding past injuries, past medical history, or suggested physical limitations relating directly to the participant's ability to participate in the camp for six or more hours per day:

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

I certify the above-named individual is able to participate fully in rigorous physical activity, based on physical examination within 12 months prior to said camp date.

\_\_\_\_\_  
(Signature of Physician) (Date)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)