



### CAMP AMERICA MEDICAL FORM

#### SECTION A - TO BE COMPLETED BY APPLICANT

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Female / Male

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Emergency Contact / Next of Kin Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Number (incl. country code): \_\_\_\_\_

Camp America must be notified if you are exposed to a communicable disease/serious injury or of any other changes to your general medical condition after completion of this form, including sprained/broken limbs which may impair performance. I confirm the information on this form is correct to the best of my knowledge. Should any emergency arise, I authorise Camp America Staff and any medical provider to release information regarding my condition to camp or their insurance provider/emergency services and I understand they can contact my next of kin or my nominated emergency contact without my prior consent. It is your responsibility to ensure you are fully vaccinated including any boosters advised by your GP. Some Summer Camps may require additional vaccinations, speak with your camp directly for more information. By signing this form I confirm I have read the insurance privacy policy (see [www.culturalinsurance.com](http://www.culturalinsurance.com)) link at bottom of "About US" section) and I confirm that I give permission for my doctor to supply my medical information to Camp America.

Signature: ..... Date: .....

#### SECTION B - TO BE COMPLETED BY PHYSICIAN ONLY (who should not be a relative of the applicant) Has the applicant ever suffered from...

- 1. Any chronic/recurring illnesses:
- 2. Any operation, serious injuries or any other pre-existing medical conditions:
- 3. Any hospitalisations of more than 3 consecutive admission days:
- 4. Any mental illness/eating disorder or self harm:
- 5. Any developmental disorders (e.g. Aspergers, Autism, OCD):
- 6. Any suicide attempts/ideations:

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Please provide details and approximate dates if you have answered 'YES' to any of the above:

To your knowledge has the applicant ever been the victim of the following:

Sexual Abuse: YES  NO  Emotional Abuse: YES  NO

Are there any emotional/mental issues that would prevent this applicant from caring for children? YES  NO

Are there any limitations to any physical activities? YES  NO

If you have answered yes to any of the questions above, please explain:

Please provide name and dosage of all medications applicant is currently prescribed to take and to which condition they relate, please include allergies. (Patient will require up to three months supply of all medicines)

Medicine: ..... Condition: .....

Any issues with the following...

	Yes	No		Yes	No
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Back Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Concussion/Head injuries	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Walking/Night Terrors	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Generalised Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Had Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders (Anorexia/Bulimia)	<input type="checkbox"/>	<input type="checkbox"/>	Other: .....		
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>			

**Susceptibilities**

Convulsions/Epilepsy: YES  NO  Date of last seizure: .....

Other (please specify): .....

**Immunisations** – please complete or alternatively print off vaccination records and attach.

Immunisation <i>*required</i>	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Most Recent Dose
	(Month/Year)	(Month/Year)	(Month/Year)	(Month/Year)	(Month/Year)	(Month/Year)
MMR* - Mumps/Measles/ Rubella						
Chicken Pox						
Diphtheria/ Pertussis/ Tetanus						
Meningitis						
Hepatitis A and B						
Typhoid						
Whooping Cough						
Polio						

Tuberculin Test Given? Yes  No  Date: ..... Positive  Negative

If the result was positive, a copy of a recent chest x-ray needs to be submitted.

Do you have access to the patient's full medical history: YES  NO

How long have you been treating the patient?.....

DOCTORS WILL NOT BE HELD LIABLE FOR THE INFORMATION PROVIDED IN GOOD FAITH TO CAMP AMERICA

DOCTOR'S SIGNATURE: ..... DATE: .....

PLEASE PRINT NAME: .....

PHONE NO.: .....

EMAIL ADDRESS: .....

**PLEASE STAMP**