# 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 privacy policy (see 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...**

| | Yes | No |
|---|---|---|
| 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: | | |

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 |
|---|---|---|
| Heart | | |
| Lungs | | |
| Migraines | | |
| Back Conditions | | |
| Fainting/Dizziness | | |
| Sleep Walking/Night Terrors | | |
| Depression | | |
| Generalised Anxiety | | |
| Self-Harm | | |
| Attempted Suicide | | |
| Eating Disorders (Anorexia/Bulimia) | | |
| Obsessive Compulsive Disorder | | |

| | Yes | No |
|---|---|---|
| Asthma | | |
| Diabetes | | |
| Tuberculosis | | |
| Rheumatic Fever/Heart Disease | | |
| Concussion/Head injuries | | |
| Measles | | |
| Mumps | | |
| Whooping Cough | | |
| Cancer | | |
| Had Chicken Pox | | |

Other: .................................................................

**Susceptibilities**

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

Other (please specify): ..................................................................................................................................

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

| **Immunisation** *required | **Dose 1** (Month/Year) | **Dose 2** (Month/Year) | **Dose 3** (Month/Year) | **Dose 4** (Month/Year) | **Dose 5** (Month/Year) | **Most Recent Dose** (Month/Year) |
|---|---|---|---|---|---|---|
| MMR* - Mumps/ Measles/ Rubella | | | | | | |
| Polio (Sabin) | | | | | | |
| Diphtheria/ Pertussis/ Tetanus | | | | | | |
| Meningitis | | | | | | |
| Hepatitis A and B | | | | | | |
| Typhoid | | | | | | |
| Whooping Cough | | | | | | |
| Chicken Pox | | | | | | |
| COVID-19 Vaccine | | | | Type of vaccine: | | |

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

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