



2012 CAMPER HEALTH INFORMATION FORM B

Camp Virginia Jaycee

Mailing Address: P.O. Box 648
Blue Ridge, Virginia 24064
Physical Address: 328 Bethel Road
Fincastle, Virginia
Office Phone: (540) 947 - 2972

FOR OFFICE USE ONLY

Date Rec'd: _____
CVJC Review: _____
Date Approved: _____

To be completed by a licensed Physician, the information must be available to Camp Virginia Jaycee a minimum of three (3) weeks prior to the camper's attendance. Please notify the Camp of exposure to any contagious disease in the three weeks prior to camp.

Camper Name: _____ **Session (s)** _____
Last First MI

Name of Family Physician _____

Emergency Contact: Primary contact in case parent or guardian cannot be reached in an emergency:

Name _____ Home Phone _____ Work _____ Cell _____

IMPORTANT NOTE TO PHYSICIAN: The information requested on this form will be used to determine this person's acceptance to Camp Virginia Jaycee. So that our staff will be able to offer the best level of care, please provide us with the most up-to-date and detailed information. Please confirm the information on the front of this form.

Birth Date: _____ Sex: Male Female Height: _____, Weight: _____, Blood Pressure: _____
(MM/DD/YYYY)

Check any of the following if applicable and give dates:

Date		Date	
	Middle Ear Infections		Heart Defect/Disease
	Swimmer's Ear		High Blood Pressure
	Hay Fever		Chicken Pox
	Measles		German Measles
	Mumps		Asthma
	Rheumatic Fever		Venereal Disease
	Hepatitis: Type:		Acquired Immune Deficiency
	Emphysema		Urinary Tract Infections
	Diabetes		Other:

Record the month & year of basic immunizations and boosters.

Date		Date	
	Diphtheria (DPT)		German Measles
	Pertussis (Whooping Cough)		Mumps
	Tetanus		Tuberculin Test or X-ray
	Oral Polio (Sabin)		Haemophilus Influenza Type B
	Injectable Polio (Salk)		Hepatitis
	Measles (Red)		

Surgery or serious injuries within the past year: _____

Chronic or recurring illness: _____

Describe any medical problems we should be prepared to handle at Camp Virginia Jaycee and what treatment is given:

CAMPER NAME: _____

FORM B

Please list below ALL medications and dosages to be taken by the applicant while he/she is participating in our program.

Medication	Dosage	Times/Schedules
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		

Please attach extra sheet if needed.

Does Applicant ever have seizures? Yes No If 'Yes', date of last seizure: _____

Is applicant subject to periods of hyperactivity? Yes No

Is medication necessary at these times? Yes No

Please describe any medical condition for which this applicant is under a physician's care and the treatment being administered.

_____.

Is applicant on a medical diet? Yes No If 'Yes' please describe _____

Any recent exposure to contagious diseases? _____ YES _____ NO

What? _____ When? _____

Specify activities in which this applicant should NOT participate and why? _____

Additional health information you feel is needed to adequately address the health needs of this camper:

I have examined this applicant on _____ and in my opinion his/her condition **does** _____
does not _____ preclude his/her attendance and active participation in the camp program.

Licensed Physician Signature: _____

Print Doctor's Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

By* _____

(initial if completed by nurse or physician's assistant)