

紐澤西 中美文化協會 夏令營  
CACA CHINESE CULTURE CAMP

健康檢查表 Health Record

The upper part to be filled in by parent/guardian of minors or by adult campers/staff members themselves.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_  
First Middle Initial Last Month Day Year

Father/Guardian: \_\_\_\_\_ Mother: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Father/Guardian Mother

Emergency Contact (please give name, address and daytime phone of two persons other than parent/guardian)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

● Past Medical History (check and give dates)

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Mononucleosis \_\_\_\_\_

Bleeding disorder \_\_\_\_\_ Heart disease \_\_\_\_\_ Psychiatric treatment \_\_\_\_\_

Chicken pox \_\_\_\_\_ Hypertension \_\_\_\_\_ Recurrent ear infection \_\_\_\_\_

Convulsions \_\_\_\_\_ Kidney disease \_\_\_\_\_ Others \_\_\_\_\_

Past surgical history: \_\_\_\_\_ Family medical history: \_\_\_\_\_ Allergies: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

● Immunization Records (dates)

DPT \_\_\_\_\_ Measles \_\_\_\_\_

HIB \_\_\_\_\_ Mumps \_\_\_\_\_

OPV \_\_\_\_\_ Rubella \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Tuberculin test: \_\_\_\_\_ result: \_\_\_\_\_

● Physical Examination by Licensed Physician:

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ B.P. \_\_\_\_\_ P \_\_\_\_\_ T \_\_\_\_\_

HEENT \_\_\_\_\_ Lungs \_\_\_\_\_ Heart \_\_\_\_\_ Abd \_\_\_\_\_ Back \_\_\_\_\_ Ext \_\_\_\_\_ Neuro \_\_\_\_\_

I have examined the person herein described and have reviewed his/her medical history.

He/She is \_\_\_\_ is not \_\_\_\_ with restrictions \_\_\_\_ to participate in camp activities.

Medication or special diet while in the camp \_\_\_\_\_

Licensed Physician's signature \_\_\_\_\_ Phone \_\_\_\_\_

Address (Please print) \_\_\_\_\_

Date of Examination \_\_\_\_\_ Date of Form Completion \_\_\_\_\_