HEALTH EXAMINATION FORM
(To be completed by your Physician)

Camper's LegalName_____

Social Security Number (Camper) _ _ _ - _ _ - _ _ _ _

Insured Parent's Legal Name_____

Social Security Number (Parent) _ _ _ - _ _ - _ _ _ _

Insured Parent Date of Birth _____

Date of Examination_____

Physician Name_____

Address_____

Telephone_____

Patient Information

Height_____ **Weight** _____ **BP**_____ **Appearance/Nutrition**_____

Code: Satisfactory = S Not Satisfactory = X Not Examined = O

_____**Without Glasses** _____ **With Glasses**

Eyes R20/_____ **L 20/**_____ **R20/**_____**L20/**_____

Ears_____ **Hearing R** _____ **L** _____

Nose_____ **Throat**_____

Heart _____ **Abdomen** _____

Lungs_____ **Hernia** _____

Genitalia _____ **Skin** _____

Musculoskeletal _____

Other Notes_____

Checked for lice _____

HEALTH EXAMINATION FORM
(To be completed by your Physician)

IMMUNIZATIONS

VACCINE DATE DOSE PROVIDER

DTAP, DTP, DT

POLIO _____

CHICKENPOX_____

MMR_____

HEPATITIS B_____

Hib _____

ROTAVIRUS _____

INFLUENZA _____

PNEUMOCOCCAL _____

HEPATITIS_____

ALLERGIES_____

OTHER _____

You will be informed of doctor visits. Prescribed medicine must be in the original container with written instructions. All medicine will be in staff care. Health insurance is not included in camp fee. All medical and transportation expenses are the parent/guardian's responsibility.

Please include a copy of the health insurance information that covers your child along with this form. Thank you!

Mail to:

3HO Foundation International
Attn: KYC
PO 1560
Santa Cruz, NM 87567