



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 situation arise, I authorise 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. By signing this form I confirm I have read the insurance 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...

- 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):

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"/>

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 Physical Abuse: YES NO Emotional Abuse: YES NO

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

*If you have answered yes to this question, 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"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Concussion/Head injuries	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
OCD	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Walking	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Night Terrors	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other:.....		
Eating Disorders (Anorexia/Bullimia)	<input type="checkbox"/>	<input type="checkbox"/>		
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>			

Susceptibilities

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

Other (please specify):.....

Immunisations

	Full course given?	Date last booster given
Diphtheria/ Pertussis/ Tetanus Toxoid	<input type="checkbox"/>	_____
Whooping Cough Vaccine	<input type="checkbox"/>	_____
Typhoid	<input type="checkbox"/>	_____
MMR – Mumps / Measles / Rubella	<input type="checkbox"/>	_____
Polio (Sabin) Vaccine	<input type="checkbox"/>	_____
Hepatitis A, B & C	<input type="checkbox"/>	_____
Meningitis Vaccine	<input type="checkbox"/>	_____

Tuberculin Test Given? Yes No Date:..... Result:.....

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?.....

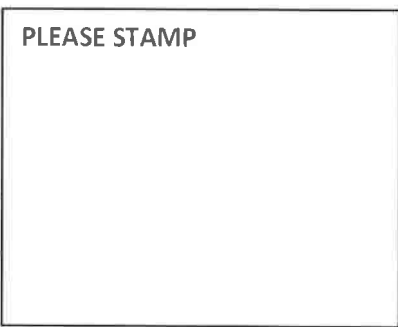
DOCTORS WILL NOT BE HELD LIABLE FOR THE INFORMATION PROVIDED IN GOOD FAITH TO CAMP AMERICA

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

PLEASE PRINT NAME:

PHONE NO.: FAX:

EMAIL ADDRESS:.....



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