Penikese Island Discovery
Explore Every Direction

Health Certificate (Page 1 of 2)

To be completed and signed by the camper or staff member's physician. The physician should not be related to the camper or staff member. Each question must be answered. For "YES" responses to questions 3–14, please provide a detailed explanation here or attached in a separate report. The staff member or the camper's parent/guardian must also sign.

CANDIDATE NAME			HOME COUNTRY
BIRTH DATE DD / MMM / YYYY	HEIGHT		WEIGHT
1 B/P	PULSE	RESPIRATION	BLOOD TYPE

2 Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration?

☐ No ☐ Yes (describe)

3 Please check the appropriate box. Has this individual HAD any of the diseases/conditions listed below:

MEASLES	☐ No	☐ Yes	IF KNOWN	Titer:	Date: / /	RHEUMATIC FEVER	☐ No	☐ Yes
MUMPS	☐ No	☐ Yes	IF KNOWN	Titer:	Date: / /	COUGH (PERSISTENT, RECURRING)	☐ No	☐ Yes
RUBELLA	☐ No	☐ Yes	IF KNOWN	Titer:	Date: / /	HEADACHES (PERSISTENT, RECURRING)	☐ No	☐ Yes
CHICKEN POX	☐ No	☐ Yes	IF YES	Month:	Year:	SLEEPWALKING	☐ No	☐ Yes
POLIOMYELITIS	☐ No	☐ Yes				ENURESIS	☐ No	☐ Yes
HEPATITIS	☐ No	☐ Yes				APPENDICITIS	☐ No	☐ Yes
TUBERCULOSIS	☐ No	☐ Yes				PARASITES (INTERNAL)	☐ No	☐ Yes

If yes, give detailed information and dates (use extra pages if necessary):

4 ACNE ☐ No ☐ Yes If yes, identify area, severity, any medication taken, name, dosage & frequency:

5 ALLERGIES ☐ No ☐ Yes If yes, identify type, any medication taken, name dosage & frequency:

6 ASTHMA ☐ No ☐ Yes If yes, identify type, severity, any medication taken, name, dosage & frequency:

7 DIABETES ☐ No ☐ Yes If yes, identify type, severity, any medication taken, name, dosage & frequency:

8 SEIZURE DISORDER ☐ No ☐ Yes If yes, identify type, severity, any medication taken, name, dosage & frequency:

9 Has the individual ever had any disease, impairment or abnormality of:

Abdominal organs, digestive system	☐ No	☐ Yes	Heart blood vessels	☐ No	☐ Yes
Lungs, respiratory system	☐ No	☐ Yes	Tonsils, nose or throat	☐ No	☐ Yes
Bones, joints, locomotor system	☐ No	☐ Yes	Blood, endocrine system	☐ No	☐ Yes
Genito-urinary system	☐ No	☐ Yes	Eyes/vision, ear/hearing	☐ No	☐ Yes

If yes, please explain (use extra pages, if necessary)

10 Has the individual been hospitalized? ☐ No ☐ Yes

If yes, give dates, diagnosis and outcome for each incident.

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CANDIDATE NAME	HOME COUNTRY

11 Is the individual currently taking medication or injections (other than mentioned previously)? ☐ No ☐ Yes

If yes, identify the medication, reason for usage, dosage and frequency:

12 Has the individual EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder? ☐ No ☐ Yes

13 Is there a history of, or present evidence of, an emotional, nervous or eating disorder? ☐ No ☐ Yes

If yes to either (12 or 13), a FULL report by the specialist and a statement by the staff member or the camper's parent/guardian about the illness or specific problem must be explained. Please attach a separate report page if necessary. Please evaluate carefully the individual's current orprevious condition and treatment along with their ability to manage adjustment to a rustic, isolated environment.

Treating specialist's name, contact information and degree:

14 Are there any health limitations or restrictions on the individual's activities and/or sports participation, or any medical information which should be considered for camp placement? ☐ No ☐ Yes

If yes, please describe:

15 Does the candidate wear glasses or contact lenses? ☐ No ☐ Yes

16 What was the date of the individual's last dental check-up?	DATE

Does the individual wear dental braces? ☐ No ☐ Yes

If yes, will orthodontic care be needed while at camp? ☐ No ☐ Yes	FREQUENCY

17 Please specify exact day, month, and year that the individual had the following immunizations:

☐ MEASLES	Dates:	☐ TETANUS	Dates:
☐ MUMPS	Dates:	☐ POLIOMYELITIS	Dates:
☐ RUBELLA	Dates:	☐ BCG	Dates:
☐ DIPHTHERIA	Dates:	☐ HEPATITIS B	Dates:
☐ PERTUSSIS	Dates:	☐ OTHER	Dates:
TB Test—which type (circle one): Mantoux or Tine	Date:	Result ☐ + ☐ -	
If positive, was chest x-ray done? ☐ No ☐ Yes	Date:	Result ☐ + ☐ -	

I, the undersigned, certify that a thorough physical examination of the camper has been given and all important recent medical information has been included on the health certificate, that nothing relevant has been omitted, and that the camper is able to attend summer camp. I understand that the omission of any information could be harmful to the camper's health care and could result in termination from camp.

PHYSICIAN NAME AND DEGREE	SIGNATURE

ADDRESS	DATE