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…

	Yes	No
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):		

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			Cancer		
Lungs			Rheumatic Fever/Heart Disease		
Migraines			Concussion/Head injuries		
Depression			Tuberculosis		
OCD			Chicken Pox		
Attempted Suicide			German Measles		
Sleep Walking			Mumps		
Fainting/Dizziness			Whooping Cough		
Night Terrors			Asthma		
Diabetes					
Eating Disorders (Anorexia/Bullimia)			Other:.....		
Self Harm			.....		

Susceptibilities

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

Other (please specify):.....

.....

Immunisations

	Full course given?	Date last booster given
Diptheria/ Pertussis/ Tetanus Toxoid		_____
Whooping Cough Vaccine		_____
Typhoid		_____
MMR – Mumps / Measles / Rubella		_____
Polio (Sabin) Vaccine		_____
Hepatitis A, B & C		_____
Meningitis Vaccine		_____

	Yes	No
Tuberculin Test Given?		

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:.....

PLEASE STAMP

UK: 37A Queens Gate, London, SW7 5HR
Poland: ul. Wierzbowa 9/11 | 00-094 Warsaw, Poland
Germany: Friedensplatz 1, 53111 Bonn, Germany
Australia: 10-14 Oxford Square, Darlinghurst NSW 2010