



**Association of Horizon, Inc.
Health Examination Form 2019
Due: June 1, 2019**

RETURN FORM TO: Jen Hanenburg Attn: Sheila Caplis
Association of Horizon Recruitment - **Camper** Association of Horizon Recruitment - **Attendant**
1970 Harvard Lane 4537 N. Mozart
New Lenox, IL 60451-3804 Chicago, IL 60625-8937
773-477-5170 773-477-5170

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **TELEPHONE:** _____

_____ **RELATIONSHIP:** _____

EMERGENCY CONTACT: _____

TELEPHONE: (home) _____ **(other)** _____

If applicant is under 18 years of age this must be parent or guardian.

Please supply all information requested. The purpose of this form is to give information to the camp health care staff to assist them in assuring a safe week for each person at camp, and to be able to provide efficient care in case of emergency.

Do you have completed advance directives? (Living Will, Power of Attorney for health care) YES / NO
If yes, please scan copies directly onto the camp application website.

HEALTH EXAMINATION This section is to be completed by a licensed physician or other health care professional.

HT: _____ **WT:** _____ **B/P:** _____ **Temp:** _____ **Heart rate:** _____

Normal OR Essential Finding, Deviating from Normal

Head: _____

Eyes/Vision: _____

Mouth/Teeth: _____

Ears/Hearing: _____

Neck/Thyroid: _____

Heart: _____

Thorax/Lungs: _____

Abdomen/Hernia: _____

Lymphatics: _____

Spine/Posture: _____

Extremities: _____

Skin/Wounds: _____

Mental Health: _____

Emotional: _____

General Appraisal or Diagnosis: _____

Recent Respiratory Infection? YES / NO If yes, give details: _____

Recent Hospitalization or Surgery? YES / NO If yes, give details: _____

Nutritional Needs: _____

Other: _____

Recommendations and Restrictions during the camp week: _____

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The person named on this form wishes to participate in a camping program for persons with physical disabilities. Participation involves being outdoors and engaging in physical activities such as swimming and boating. Persons without physical disabilities may be required to do lifting. Please determine whether or not you consider this person physically and emotionally able to participate, and identify any specific restrictions that are required.

In your estimation, is this person able to attend and participate in a camping program, except as identified by your recommendations and restrictions? YES / NO

Examiner's Signature: _____ **Date:** _____

Print Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

CAMP APPLICANT NAME: _____ **DATE OF BIRTH:** _____