Camp America EST 1969

CAMP AMERICA MEDICAL FORM

SECTION A - TO BE COMPLETED BY APPLICANT

First Name: Ahmed Last Name: Saad Female / Male

Height: 170 CM Weight: 90 KGs Age: 22 Date of Birth: 12/09/1997

Emergency Contact / Next of Kin Information

First Name: Nehad Last Name: El behiry

Relationship: Mother Contact Number (incl. country code): 00201023766659

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 arise, I authorise Camp America Staff and 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. It is your responsibility to ensure you are fully vaccinated including any boosters advised by your GP. Some Summer Camps may require additional vaccinations, speak with your camp directly for more information. 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: [signature] Date: 02/18/2020

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):		✓
6. Any suicide attempts/ideations:		✓

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 ☑ Emotional Abuse: YES ☐ NO ☑

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

Are there any limitations to any physical activities? YES ☐ NO ☑

If you have answered yes to any of the questions above, 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		✓	Asthma		✓
Lungs		✓	Diabetes		✓
Migraines		✓	Tuberculosis		✓
Back Conditions		✓	Rheumatic Fever/Heart Disease		✓
Fainting/Dizziness		✓	Concussion/Head injuries		✓
Sleep Walking/Night Terrors		✓	Measles		✓
Depression		✓	Mumps		✓
Generalised Anxiety		✓	Whooping Cough		✓
Self Harm		✓	Cancer		✓
Attempted Suicide		✓	Had Chicken Pox	✓	
Eating Disorders (Anorexia/Bulimia)		✓			
Obsessive Compulsive Disorder		✓	Other:		

Susceptibilities

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

Other (please specify): .....

Immunisations – please complete or alternatively print off vaccination records and attach.

Immunisation *required	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)	Most Recent Dose (Month/Year)
MMR* - Mumps/ Measles/ Rubella	1/1998	2/1998				
Chicken Pox	5/2008	6/2008				
Diphtheria/ Pertussis/ Tetanus	1/1998	2/1998				
Meningitis	1/1998	2/1998				
Hepatitis A and B	1/1998	2/1998				
Typhoid	1/1998	2/1998				
Whooping Cough	1/1998					
Polio	2/1998	4/1998	6/1998			

Tuberculin Test Given? Yes ☑ No ☐ Date: 1/2/25 Positive ☐ Negative ☑

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? one year

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

DOCTOR'S SIGNATURE: Dr Hany Abou DATE: 26/2/2026

PLEASE PRINT NAME: Dr Hany Abou Shama

PHONE NO.: 0505939

EMAIL ADDRESS: Abo shama@Hotmail.Com

PLEASE STAMP

دكتور
هاني محمد ابو شامه
استشاري اول طب طوارئ
باطنة - قلب