

HEALTH RECORD FOR CHILDREN IN DAY CAMP, AFTERSCHOOL & YOUTH CENTERS

(This side is to be completed by Parent before presenting to Physician)

NAME OF PROGRAM: Cortelyou Day Camp

CHILD'S LAST NAME _____ CHILD'S FIRST NAME _____ DATE OF BIRTH _____ FEMALE MALE

HOME ADDRESS _____ CITY/STATE/ZIP CODE _____ HOME TELEPHONE NUMBER _____

PARENT'S OR GUARDIAN'S NAME _____ CONTACT TELEPHONE _____

FATHER'S PLACE OF EMPLOYMENT _____ TELEPHONE _____

MOTHER'S PLACE OF EMPLOYMENT _____ TELEPHONE _____

IN CASE OF EMERGENCY-NOTIFY _____ TELEPHONE _____

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY, NOTIFY: (FAMILY PHYSICIAN)

1. _____ TELEPHONE _____

OR TELEPHONE _____

2. _____ TELEPHONE _____

IMPORTANT: Please notify Camp Officials if Child was/is exposed to any communicable disease at anytime three weeks prior to Camp attendance.

NO YES If YES, please give type of exposure: _____

HEALTH HISTORY (Check, giving approximate dates):

Asthma: _____ Behavior: _____ Chicken Pox: _____

Convulsion: _____ Diabetic: _____ Ear Infection: _____

Hay Fever: _____ Insect Stings: _____ Ivy Poisoning, etc: _____

Measles: _____ German Measles: _____ Mumps: _____

Past Illness: _____ Contagious illness: _____

Other Drugs: _____ Penicillin: _____ Rheumatic Fever: _____

Operations or Serious Injuries (Dates): _____

Hospitalization: _____

Chronic or Recurring Illness: _____

Other Diseases or details of above: _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

Permission for all program activities unless otherwise noted by physician: _____

Suggestion from Parent(s) or Guardian: _____

SIGNIFICANT HEALTH HISTORY AND CURRENT CONDITIONS

PLEASE LIST:

Medication taken: _____

Appliance worn (Glasses, Hearing Aid, etc.): _____

Conditions that modify activity (seizures, asthma, heart condition, etc.): _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby give my consent/authority to the Staff of the Day Camp, year round Afterschool, and Youth Center Program to obtain the necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship: _____ Signature: _____ Telephone: _____ Date: _____

(To be filled out by Physician – Please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the need of the aforementioned Child in Day Camp and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY (This is a record of dates of basic immunization and most recent booster doses)

DPT or DT or TD – DATE: DATE: DATE: DATE: DATE:
POLIO - DATE: DATE: DATE: DATE: DATE:
MEASLES- DATE:
MUMPS- DATE:
RUBELLA- DATE:

(PPD-MANTOUX)

Tuberculin Test given: (most recent) Result: m m

MEDICAL EXAMINATION (To be completed by licensed Physician)

EXAMINATION IS ACCEPTABLE WHEN PERFORMED NO MORE THAN 12 MONTHS PRIOR TO ARRIVAL AT CAMP.
CODE: S = SATISFACTORY X = NOT SATISFACTORY (EXPLAIN) O = NOT EXAMINED

GENERAL APPEARANCE

HEIGHT WEIGHT BLOOD PRESSURE HGB. TEST
URINALYSIS POSTURE & SPINE THROAT/TONSILS
EYES VISION GLASSES EXTREMITIES
HEART EARS HEARING FEET
LUNGS SKIN NOSE TEETH
ABDOMEN HERNIA GENITALIA

ALLERGY (PLEASE SPECIFY):
EUROLOGICAL FINDINGS:
DESCRIBE ABNORMAL FINDINGS AND/OR HANDICAPPING CONDITIONS:

HAS CHILD EVER RECEIVED PRODUCTS CONTAINING HORSE SERUM? NO YES If YES, Please explain.

SPECIAL DIET

MEDICAL MEDICATION (GIVE NAME AND DOSAGE)

PARENT/GUARDIAN SEEKING SPECIAL MEDIATION?

SWIMMING DIVING STRENUOUS ACTIVITY

GENERAL APPRAISAL:

I HAVE EXAMINED THE INDIVIDUAL HEREIN DESCRIBED, REVIEWED HIS/HER HEALTH HISTORY AND IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP/YEAR ROUND AFTERSCHOOL AND YOUTH CENTER ACTIVITIES, EXCEPT AS NOTED ABOVE.

PHYSICIAN'S SIGNATURE M.D. DATE

ADDRESS CITY/STATE ZIP CODE