

Health Record for Children in Day Camps and After School & Youth Centers

This side to be completed by parent/guardian before presentation to physician.

**COMPLETE
BOTH SIDES AND
SIGN BELOW.**

Name of Program: The Park Slope Day Camp and/or Kids Orbit

Child's Last Name _____ Child's First Name _____ DOB ____/____/____ Male Female

Home Address _____ Phone _____

Parent or Guardian _____ Phone _____

Place of Employment _____

Parent/Guardian 1 _____ Phone _____

Parent/Guardian 2 _____ Phone _____

If Parent, Guardian are not available in an emergency, notify:

1 _____ Phone _____

2 _____ Phone _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
 Yes No If yes, state type exposure _____

Health History Check, giving approximate dates. Write "N/A" for all that does not apply. DO NOT LEAVE BLANK.

	Allergies	Diseases
<input type="checkbox"/> Ear Infections _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Chicken Pox _____
<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Ivy Poisoning etc _____	<input type="checkbox"/> Measles _____
<input type="checkbox"/> Convulsion _____	<input type="checkbox"/> Insect Stings _____	<input type="checkbox"/> German Measles _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Mumps _____
<input type="checkbox"/> Behavior _____	<input type="checkbox"/> Other Drugs _____	<input type="checkbox"/> Asthma _____

Past Illnesses _____ Contagious Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

To be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Suggestion from Parent/Guardian _____

Significant Health History/Current Conditions Please List

Medications Taken _____

Appliances Worn (Glasses, etc.) _____

Conditions which modify activity (Seizures, Amnesia, Heart Conditions, etc.) _____

Consent for Emergency Medical Treatment

I do hereby give authority to the Day Camp & Year Round After School and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature _____ Relationship _____

Date _____ Phone _____

Physical Examination

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 needs of this child in Day Camps and After School and Youth Center programs.

Child's Last Name _____ **First Name** _____

Immunization History This is a record of dates of basic immunizations and most recent booster doses.

DPaP, DTP or TD Date _____ Date _____ Date _____ Date _____ Date _____

Polio Date _____ Date _____ Date _____ Date _____ Date _____

MMR Date _____ Date _____ Date _____ Date _____ Date _____

Hemophilus Influenzae Type B Date _____ Date _____ Date _____ Date _____

Hepatitis B Date _____ Date _____ Date _____

Varicella Date _____ Date _____

Other _____ Date _____ Date _____

Medical Examination - To be filled out 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 (Date) _____

Urinalysis (Date) _____ Posture & Spine _____ Throat/Tonsils _____

Eyes _____ Vision _____ Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____ Feet _____ Lungs _____ Skin _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____

Genitalia _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

Has child ever received products containing horse serum? _____

Allergies (Please specify) _____

Recommendations and restrictions while in camp

Special Diet _____

Special Medicine (name it) _____

Is parent/guardian sending special medicine? _____

Swimming _____ Diving _____

Activity Restrictions _____

General Appraisal _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round After School and Youth Center activities, except as noted above.

Examining Physician (Signature) M.D.

Physicians Name (Please Print)

Date of Examination

Address

Phone