

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

CHILD'S LAST NAME _____

FIRST NAME _____

/ /
BIRTHDATE _____

M F
SEX _____

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

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

1. _____ Phone: _____

or 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 of exposure: _____)

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infections _____

Allergies
Hay Fever _____

Diseases
Chicken Pox _____

Rheumatic Fever _____

Ivy Poisoning, etc. _____

Measles _____

Convulsion _____

Insect Stings _____

German Measles _____

Diabetes _____

Penicillin _____

Mumps _____

Behavior _____

Other Drugs _____

Other Contagious Illnesses _____

Asthma _____

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

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

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool 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.

Relationship _____ Signature _____ Date _____ Tele.# _____

Department of Health and Mental Hygiene — The City of New York — Bureau of Food Safety and Community Sanitation

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 Afterschool and Youth Center programs.

IMMUNIZATION HISTORY - This is a record of dates of basic immunization and most recent booster doses.

DPaP, DTP or TD	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	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)
0 = Not Examined

General Appearance _____
Height _____ Weight _____ Blood Pressure _____ Hgb. Test (Date) _____
Urinalysis (Date) _____ Posture & Spine _____ Throat - Tonsils _____
Eyes _____ Vision _____ w/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? _____
Allergy: (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 Afterschool and Youth Center activities, except as noted above.

EXAMINING PHYSICIAN (SIGNATURE) M.D.

PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____

ZIP CODE