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 ______________________ **Permit No. 85** __________

______________ 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 ______	Hay Fever ______	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 herby 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.# __________

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 ______	Date ______	Date ______	Date ______
Hemophilus Influenzae type b	Date ______	Date ______	Date ______	Date ______	Date ______
Hepatitus B	Date ______	Date ______	Date ______	Date ______	Date ______
Varicella	Date ______	Date ______	Date ______	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 = No 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.

______ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

______
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone ______ Address ______

Date of Examination ______ ______
ZIP CODE