

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.

Table with 6 columns for different immunizations (DTaP, Polio, MMR, Hib, Hepatitis B, Varicella, PCV, Other) and 6 rows for Date entries.

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
Genitalia
Height Weight Blood Pressure Posture & Spine Throat - Tonsils
Nose Teeth Abdomen Hernia Feet Lungs Skin
Hgb. Test (Date) Urinalysis (Date)
Eyes Vision w/Glasses Extremities Heart
Ears Hearing
Neurological Findings
Describe Abnormal Findings and/or Handicapping Conditions
Allergy: (Please specify)

Recommendations and restrictions while in camp:

Special Diet
Special Medicine (dose, route of administration, when should it be administered)
Is parent/guardian sending special medicine?
Activity Restrictions
Swimming Diving

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

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 / / SEX M F

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 box if child has had afflictions, give appropriate dates)

- Rheumatic Fever _____
 Seizures _____
 Diabetes _____
 Asthma _____
 Chicken Pox _____

- Allergies
 Hay Fever _____
 Poison Ivy, etc. _____
 Insect Stings _____
 Penicillin _____
 Other Drugs _____
 Food _____

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 _____ Tel.# _____

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