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: ____

______________________ ______________________ ____/____/____ ○ FEMALE ○ MALE
CHILD'S LAST NAME CHILD'S FIRST NAME DATE OF BIRTH

______________________ ______________ ______________
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.____________________________________ ______________
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 EXAMNATION *(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 APPERANCE

HEIGHT	WEIGHT	BLOOD PRESSURE	HGB. TEST
URINALYSIS	POSTURE & SPINE	THROAT/TONSILS	
EYES	VISION	GLASSES	EXTREMETIES
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.

_______________________M.D. PHYSICIAN'S SIGNATURE _______________ DATE

ADDRESS CITY/STATE ZIP CODE