

# 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 \_\_\_\_\_

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: \_\_\_\_\_

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)

### Allergies

Rheumatic Fever \_\_\_\_\_  Hay Fever \_\_\_\_\_

Seizures \_\_\_\_\_  Poison Ivy, etc. \_\_\_\_\_

Diabetes \_\_\_\_\_  Insect Stings \_\_\_\_\_

Asthma \_\_\_\_\_  Penicillin \_\_\_\_\_

Chicken Pox \_\_\_\_\_  Other Drugs \_\_\_\_\_

Food \_\_\_\_\_

Other Past Illnesses: \_\_\_\_\_

Operations or Serious Injuries (Dates): \_\_\_\_\_

Hospitalization (Dates): \_\_\_\_\_

Chronic or Recurring Illness (Dates): \_\_\_\_\_

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 takes:** \_\_\_\_\_

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.#: \_\_\_\_\_

## 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 Youth Center programs.

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

DTaP, DTP, DT, Td    Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Polio                    Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

NMR                     Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Hemophilus Influenza type b (Hib)    Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Hepatitis B            Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Varicella              Date: \_\_\_\_\_ Date: \_\_\_\_\_

Pneumococcal        Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Conjugate (PCV)

Other                    Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

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**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): \_\_\_\_\_

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: \_\_\_\_\_

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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

\_\_\_\_\_  
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ ZIP CODE \_\_\_\_\_