Health Record for Children in Day Camps and After School & Youth Centers
This side to be completed by parent/guardian before presentation to physician.

COMPLETE BOTH SIDES AND SIGN BELOW

Name of Program: ____

______________________ ______________________ DOB_____/_____/_____ ☐ MALE ☐ FEMALE
Child's Last Name Child's First Name

Home Address________________________________ Phone________________________

Parent or Guardian________________________________ Phone________________________

Place of Employment

Parent/ Guardian 1____________________________ Phone________________________

Parent/ Guardian 2____________________________ 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 exposure ____

Health History

Check, giving approximate dates. Write "N/A" for all that does not apply. DO NOT LEAVE BLANK.

	Allergies	**Diseases**
☐ Ear Infection ________	☐ Hay fever ________	☐ Chicken Pox ________
☐ Rheumatic Fever ________	☐ Poison Ivy, etc. ________	☐ Measles ________
☐ Seizures ________	☐ Insect Stings ________	☐ German Measles ________
☐ Diabetes ________	☐ Penicillin ________	☐ Mumps ________
☐ Behavior ________	☐ Other Drugs ________	
☐ Asthma ________	☐ Food ________	

Past Illnesses ______________________________ Contagious Illnesses ______________________________

Operations or Serious Injuries (Dates) ____

Hospitalization (Dates) ____

Chronic or Recurring Illness ____

Operations or Serious Injuries (Dates) ____

Any specific activities to be encouraged? ____

Conditions that require activity to be restricted? ____

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

Suggestions from Parent/ Guardian ____

Significant Health History/Current Conditions

Please List

Medications Taken ____

Appliances Worn (glasses, contacts, etc.) ____

Conditions which modify activity (Seizures, Amnesia, Heart Conditions, etc.) ______________________________

Consent for Emergency Medical Treatment

I do hereby give authority to the Day Camp & Year Round After School 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.

Signature ______________________________ Relationship ______________________________

Date ______________________________ Phone ______________________________

Physical Examination

To be filled out by licensed 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 After School and Youth center programs.

Child's Last Name_______________________________ **First Name**_______________________________

Immunization History This is a record of dates of basic immunizations and most recent booster doses.

DPaP, DTP or TD	Date ________	Date ________	Date ________	Date ________
Polio	Date ________	Date ________	Date ________	Date ________
MMR	Date ________	Date ________	Date ________	Date ________
Hemophilus Influenzae Type B	Date ________	Date ________	Date ________	Date ________
Hepatitis B	Date ________	Date ________	Date ________	Date ________
Varicella	Date ________	Date ________	Date ________	Date ________
PCV	Date ________	Date ________	Date ________	Date ________
Other ________________________			Date ________	Date ________

Medical Examination - To be filled out by physician

Examination is acceptable when performed no more than 12 months prior to arrive at camp.

Code: S = Satisfactory X = Not Satisfactory (Explain) O = Not Examined

General Appearance____

Height ________ Weight ________ Blood Pressure ________ HGB Test (Date) ________

Urinalysis (Date) ________ Posture & Spine ________ Throat / Tonsils ________

Eyes ________ Vision ________ 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? ______________________________

Allergies (Please specify) ____

Recommendations and restrictions while in camp

Special Diet ____

Special Medicine (please specify) ______________________________

Is parent/guardian sending special medicine? ______________________________

Swimming ____________________ Diving ____________________

Activity Restrictions ____

General Appraisal ____

I have examined the person herein described, reviewed his/her health and it is my opinion that he/she is physically able to engage in Day Camp & Year Round After School and Youth Center Program activities, except as noted above.

______________________________ M.D.
Examining Physician (Signature)

____
Physicians Name (Please Print)

____
Date of Examination

____
Phone

____
Address