

**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 \_\_\_\_\_

\_\_\_\_\_ / / \_\_\_\_\_  M  F  
 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: \_\_\_\_\_

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,	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 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 \_\_\_\_\_ 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.

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### 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 _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	Date _____
Varicella	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	_____	_____	_____	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 = 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 \_\_\_\_\_

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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: \_\_\_\_\_

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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) M.D.

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

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

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