

2010 Health Record for Children in Day Camps

THIS RECORD MUST BE SUBMITTED AT LEAST 4 WEEKS BEFORE THE FIRST DAY OF CAMP.

Parents, please fill out this side before presenting this form to your child's physician.

Child's Last Name _____ First Name _____ Date of Birth _____ M F

Home Address _____ Home Phone _____

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

If parent or guardian is not available in an emergency, please notify: _____

Family Physician _____ Phone _____

Other emergency contact _____ Phone _____

HEALTH HISTORY (Please check and give approximate dates.)

	ALLERGIES	DISEASE
<input type="checkbox"/> Ear infections _____	<input type="checkbox"/> Hay fever _____	<input type="checkbox"/> Chicken pox _____
<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Poison Ivy, etc. _____	<input type="checkbox"/> Measles _____
<input type="checkbox"/> Convulsions _____	<input type="checkbox"/> Insect stings _____	<input type="checkbox"/> German measles _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Behavior problems _____	<input type="checkbox"/> Other drugs _____	
	<input type="checkbox"/> Food _____	

Past Illnesses: _____ Hospitalization (give dates): _____

Operations or Serious Injuries (Give Dates): _____

Life-Threatening Allergies: _____
(You MUST contact the Camp Health Office to coordinate safety plan for your child)

Chronic or Recurring Illnesses: _____

Other Diseases or Details of Above: _____

Any Specific Activities to be Encouraged? _____

Any specific activities, including swimming, to be restricted? _____
(Children will participate in all program activities unless noted here or by physician.)

SIGNIFICANT HEALTH HISTORY/CURRENT CONDITIONS (please list)

Medications or Supplements Taken: _____

Emergency Medication Needed for Allergy Listed Above _____
(You MUST have your physician complete an allergy action plan if medication is taken or administered during camp hours)

Appliances Worn (Glasses, etc.): _____

Conditions That Restrict Activity (Seizures, Amnesia, Heart Conditions, etc.): _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event of any emergency involving my child and during which I or my designee is not accessible, I do hereby give authority to the staff of Poly Prep Summer 2010 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: _____

DO NOT SEND THIS PORTION OF THE FORM WITHOUT PHYSICAL EXAM PORTION ATTACHED.

Patient's Name: _____ Date of Birth: _____

Physical Examination

This side must be filled out by a licensed physician. In place of this form, physical examination and immunization history form may be provided by the physician.

Check here if your child is a current Poly Prep student and you would like a copy of his or her medical forms transferred to the Summer Programs Office.

Please check here if you would like this form to be forwarded to the Poly Prep school nurse to satisfy the school year form requirement.

Please sign here: _____

IMMUNIZATION HISTORY

DPT/DTaP or Td Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

IPV/OPV Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Measles Date: _____ Date: _____

Rubella Date: _____ Date: _____ Tdap: _____

Mumps Date: _____ Date: _____

Hepatitis B Date: _____ Date: _____ Date: _____

HIB Date: _____

Meningitis Date: _____ Other: _____

PPD (Mantoux)* Date Given: _____ Date Read: _____ Result mm: _____

VZV Date: _____ Date: _____ DiseaseDate: _____

MEDICAL EXAMINATION CODE: S = SATISFACTORY X = NOT SATISFACTORY (EXPLAIN) O = NOT EXAMINED

General Appearance: _____

Height: _____ Weight: _____ Blood Pressure: _____ Hgb. Test: _____

Urinalysis: _____ Posture and Spine: _____ Throat and Tonsils: _____

Eyes: _____ Vision: _____ Glasses: _____ Extremities: _____ Heart: _____

Ears: _____ Hearing: _____ Feet: _____ Lungs: _____ Skin: _____

Nose: _____ Teeth: _____ Abdomen: _____ Hernia: _____ Genitalia: _____

Allergies (please specify):

Life-Threatening Allergies: Yes No (Separate order and action plan required)

Neurological Findings: _____

Abnormal Findings or Handicapping Conditions (Please describe): _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP

Special Diet: _____

Medications (List names and dosages): _____

Is Camper Able to Self-Administer Medication? Yes No

Swimming: _____ Strenuous Activity: _____

General Appraisal: _____

I have examined this child, reviewed his or her health history, and state that in my opinion he or she is physically able to engage in activities offered by Poly Prep Summer 2010, except as noted above.

Examining Physician's Signature: _____ Date of Examination: _____

Physician's Name: _____

Address: _____ Telephone: _____

*NYC Board of Health/Bureau of Day Camps requires this information. If you feel your patient is not an At Risk Child, please attach notification of the same on office letterhead.