HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PRO	GRAM				
			/	/	$M \square F \square$
	D'S LAST NAME F	IRST NAME	В	IRTHDATE	SEX
Home Address:			Pho	ne:	
Parent or Guardi	an:		Pho	ne:	
Place of Employ	ment: Father (Guardian)		Phor	ne: ———	
	Mother (Guardian)		Phor	ne:	
In case of emerg	ency, notify:	Phor	ne:		
If Parent, Guard	ian are not available in an emergency, notify	:			
1					
or 2			Phor	ne:	
-	as this camper been exposed to any communes \(\sigma\) No \(\sigma\) (If yes, state type of exposure		•	-	•
HEALTH HIST	CORY: (Check box if child has had affliction		riate dates) ergies		
	Rheumatic Fever		Hay Fever		
	Seizures		Poison Ivy, etc		
_	Diabetes	_	Insect Stings		
_	Asthma		Penicillin		
	Chicken Pox		Other Drugs		
_		_	Food		
Other Past Illnes	ses				
	erious Injuries (Dates)				
_	Dates)				
	rring Illness				
	ivities to be encouraged?				
• •	require activity to be restricted?				
	ll program activities unless otherwise noted				
	(glasses, contacts, etc.)	•			
Medication take	en				
Suggestion from	Parent/Guardian				
	CONSENT FOR EMERG ive authority to the Day Camp and Year Roun al treatment for my child with the understand	d Afterschool d	and Youth Center Pr	ogram staff to	-
Relationship	Signature		Date	Tel.#_	
Department of I	Health and Mental Hygiene — The City o	f New York	Bureau of Food	Safety and C	Community Sanitation

PHYSICAL EXAMINATION

(<u>To be filled out by Physician – please note information on reverse side</u>)

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.

			1 6				
IMMUNIZATION F	HISTORY – Th	is is a record of dates o	f basic immunizat	ion and most re	cent booster	doses.	
DTaP, DTP, DT, Td	Date	Date	Date	Dat	e	Date	
Polio	Date	Date	Date	Dat	e	Date	
MMR	Date	Date	Date				
Hemophilus Influenza	ae type b (Hib)	Date	Date	Dat	e	Date	
Hepatitis B	Date			Dat	e		
Varicella	Date	Date					
Pneumococcal Conjugate (PCV)	Date	Date	Date	Dat	e	Date	
Other					er		
MEDICAL EXAMIN	NATION – To be	filled out by licensed j	physician.				
		performed no more tha		to arrival at car	mp.		
Code: $S = Sat$	tisfactory						
	ot Satisfactory (I	Explain)					
	ot Examined	1					
General Appearance							
1.1							
Height	Weight	Blood Pressure	Posture	& Spine	Throat	t - Tonsils	
		Abdomen					
Hgb. Test (Date)		_ Urinalysis (Date)		-			
EyesVisio	on	w/Glasses	_ Extremities		Heart		
Ears Hea	aring	_					
Neurological Finding	gs						
Describe Abnormal F	findings and/or I	Handicapping Condition	ns				
Allergy: (Please spec	ify)						
Recommendations an	d restrictions wl	hile in camp:					
Special Diet							
1		of administration, when	n should it be adm	inistered)			
•		cial medicine?					
		eiai meaieme.					
			•				
General Appraisal:							
		scribed, reviewed his/h terschool and Youth Ce	•			the is physically a	able to
							M.D.
				EXA	MINING PHYSIC	CIAN (SIGNATURE)	
				PH	IYSICIAN'S NAM	IE (PLEASE PRINT)	
Telephone		Address					
Date of Examination							
						ZI	P CODE

DCR 7 (Rev. 2/04)