HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTER SCHOOL & YOUTH CENTERS

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

NAME OF PROGRAM ___ **Leaders After School** ______________

________________ ________________ ____/____/____ M☐ F☐

Children's Last Name First Name Birth Date Sex

Home Address: ______________________________ Phone: ______________

Parent or Guardian: ______________ ______________ Phone: ______________

Parent's cell phone (Mom/Dad)______________ E-Mail ______________ @________

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 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 ______________________________

Any specific activities to be encouraged? ______________________________

Conditions that require activity to be restricted? ______________________________

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

Appliance worrn (glasses, contacts, etc.) ______________________________

Medication taken ______________________________

Suggestion from Parent/Guardian ______________________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Leaders Day Camp and Year Round Afterschool 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 to the child __________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 Afterschool and Youth Center programs.

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__________

MMR Date_________ Date_________ Date_________ Date_________ Date__________

Hemophilus Influenzae type b (Hib) Date_________ Date_________ Date_________ Date_________

Hepatitis B Date_________ Date_________ Date_________ Date_________

Varicella Date_________ Date_________

Pneumococcal Conjugate (PCV) Date_________ Date_________ Date_________ Date_________ Date_________

Other_____________ Date_________ Other_____________ Date_________ Other____________ Date_________

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) ______________

Eyes________ Vision________ w/Glasses________ Extremities_________ Heart_________ 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:____

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 ___________________________M.D. (SIGNATURE)

PHYSICIANS NAME _________________________________ (PLEASE PRINT)

Telephone ______________________ Address____

Date of Examination ______________ City ______________________ State__________ Zip Code _________________

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