

**Health Record for Children in Day Camps, After School, and Youth Centers**  
(This side to be filled in by parent before presentation to physician)

Name of program \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Child's Last Name                      First Name                      Birth Date                      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 expose: \_\_\_\_\_)

**Health History:** (Check, giving approximate dates)

Ear Infections \_\_\_\_\_

Hay Fever \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Ivy Poisoning, etc. \_\_\_\_\_

Measles \_\_\_\_\_

Convulsion \_\_\_\_\_

Insect Stings \_\_\_\_\_

German Measles \_\_\_\_\_

Diabetes \_\_\_\_\_

Penicillin \_\_\_\_\_

Mumps \_\_\_\_\_

Behavior \_\_\_\_\_

Other Drugs \_\_\_\_\_

Other Contagious Illness \_\_\_\_\_

Asthma \_\_\_\_\_

Other Past Illnesses \_\_\_\_\_

Operations or Serious Injuries (Dates) \_\_\_\_\_

Hospitalizations (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 \_\_\_\_\_

Suggested from Parent/Guardian \_\_\_\_\_

**Consent for Emergency Medical Treatment**

I do hereby give authority to the Day Camp and 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

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, After School and Youth Center programs.

**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 Influenza type b					
Hepatitis B	Date _____	Date _____	Date _____	Date _____	Date _____
Varicella	Date _____	Date _____			
Other _____				Date _____	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 \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hgb. Tes: (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 Abdominal Findings and/or Handicapping Conditions \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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, After School 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 \_\_\_\_\_