

Mosholu Montefiore Children's Health Record

(This side to be filled out by parent)

Name Of Program _____

_____ / ____ / ____ M / F
Child's Last Name Child's First Name Birth Date Sex

Home Address: _____ Phone: _____
Mother Name: _____ Phone: _____
Father Name: _____ Phone: _____
Emergency Contact _____ Phone: _____

If none of the above is available contact:
_____ Phone: _____

Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance ___yes ___no (if yes, type of exposure_____)

Health History: (Check giving approximate dates)

<u>Allergies</u>	<u>Diseases</u>	
_____ Ear Infections	_____ Hay Fever	_____ Chicken Pox
_____ Rheumatic Fever	_____ Poison Ivy	_____ Measles
_____ Convulsion	_____ Insect Stings	_____ German Measles
_____ Diabetes	_____ Penicillin	_____ Mumps
_____ Behavior	_____ Other Drugs	_____ Other Illnesses
_____ Asthma		

Other Past Illnesses _____
Operations or Serious Injuries (dates) _____
Hospitalization (dates) _____
Chronic or Recurring Illness _____
Any specific activities to be encouraged? _____
Any conditions that require activity restrictions? _____
Appliances worn (glasses, contacts, etc.) _____
Medication taken (what & how often?) _____
Suggestions from parent/ guardian _____

Consent For Emergency Medical Treatment

I do hereby give authority to the camp/ after school and program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature Relationship to child Date Telephone #

PHYSICAL EXAMINATION

(To be filled out by a Physician- Please note information on reverse side)

Child's Name _____

IMMUNIZATION HISTORY- This is a record of dates of basic immunizations and booster doses.

DpaP.DTP or TD	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____	Date _____
Hemophilus Influenzae type b	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____
Varicella	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Date _____	Date _____	Date _____

PHYSICAL EXAMINATION- acceptable when performed no more than 12 months prior to camp

Code: S-Satisfactory, X- Not Satisfactory (explain) O- 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 _____

Description of abnormal findings or handicapping conditions _____

Has child ever received products containing horse serum? _____

Allergies _____

Recommendations and restrictions while in camp.

Special Diet _____

Special Medicine (name it) _____

Is parent/guardian sending medication? _____

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 and Youth Program activities, except as noted above.

Examining Physician Signature MD Please Print Physician's Name

Telephone _____ Address _____