Mosholu Day Camps: Camper Health Form

Please Print Clearly

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Sex	Date of Birth	Camp Unit

Home Address	Apt #	City/Borough	Home Phone

Parent's Last Name	First Name	Cell Phone	E-mail

Other Parent's Last Name	First Name	Cell Phone	E-mail

Emergency Contact Name (*other than parent*)	Cell Phone	Home Phone

TO BE COMPLETED BY HEALTH CARE PROVIDER

If "yes" to any item, please explain (attach addendum, if needed)

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development	☐	☐
Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language	☐	☐
Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS

	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___ ___/___/___	_____ µg/dL _____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	___/___/___	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	___/___/___	_____ g/dL _____ %

Tuberculosis

Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school

	Date Done	Results
PPD/Mantoux *placed*	___/___/___	Induration _____mm
PPD/Mantoux *read*	___/___/___	☐ Neg ☐ Pos
Interferon Test	___/___/___	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	___/___/___	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	___/___/___ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES

CIR Number of Child

Hep B	___/___/___	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___	___/___/___
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___

Influenza	___/___/___	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___	
Td	___/___/___	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	Hep A	___/___/___	___/___/___
Meningococcal	___/___/___	___/___/___		
HPV	___/___/___	___/___/___	___/___/___	___/___/___
Other, *Specify:* _____	___/___/___ :	_____	___/___/___	

RECOMMENDATIONS

☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT

☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ _____

_____ _____

_____ _____

Health Care Provider Signature	Date ___/___/___
Health Care Provider Name and Degree *(print)*	Provider License No. and State
Facility Name	National Provider Identifier (NPI)
Address / City / State / Zip	
Telephone ( ) ___ ___ ___ – ___ ___ ___ ___	Fax ( ) ___ ___ ___ – ___ ___ ___ ___

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER: