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 ☐ Orthopedic injury/disability

☐ Chronic or [illegible] ☐ [illegible]

☐ Congenital [illegible] acquired heart disorder ☐ Speech, hearing, or visual impairment

☐ Developm[illegible]tal/learning problem ☐ Tuberculosis *(latent infection or disease)*

☐ Diabetes [illegible]tach MAF) ☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

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

☐ None ☐ Yes *(list below)*

_____

_____

[illegible]ietary 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)* _____ / _____

Ge[illegible]ral Appearance:

	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
[illegible]	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	[illegible]in	☐	☐	Psychosocial Development
[illegible]	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	[illegible]urological	☐	☐	Language
[illegible]	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	[illegible]ck/spine	☐	☐	Behavioral

Des[illegible]ribe 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
		_____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
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:

SUPPLEMENTARY HEALTH INFORMATION and CONSENT REQUEST

Camper's Name: _____ Date of Birth _____

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

New York State Public Health Law requires that a parent or guardian of campers who attend a children's camp to complete and return the following form to the camp.

Check one box and sign below.

☐ My child has had meningococcal meningitis immunization within the past 10 years.
Date received: _____

[Note: If your child received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

SUN SCREEN & FIRST AID TOPICAL OINTMENT CONSENT

☐ I consent to have my child use the sunscreen s/he has brought or the camp has supplied, which is approved by the FDA for over the counter use to avoid overexposure to the sun. My child may be assisted by camp counselor staff if s/he requests.

☐ I consent to have the camp staff use topical ointment for wounds, bug bites, etc. in the treatment of basic first aid.

CURRENT MEDICATIONS

Please list any medications (prescription or non prescription) your child is currently taking.

Tetanus Shot

Month/ Year of last Tetanus Shot _____

I accept all terms of enrollment and give permission for my child to participate in all activities including trips away from the campsite. I understand that the camper cannot attend with out an updated & signed medical form and that MMCC assumes no responsibility for personal property. I agree that photos taken by the camp may be used for publicity purposes and I agree to make payment in full before the start of the session. I also give the camp the authority to obtain necessary emergency medical treatment for my child.

_____ _____
Parent Signature Date

Transportation Information Sheet

Please fill out and return to the camp office as soon as possible

Campers Last Name	First Name	Unit

If you request that your child sign him/her self out and walk home alone, please sign here:
(Note: No Mosholu Day Camp child will be allowed to walk home alone from a late night!)

Please list anyone authorized to pick up and sign out your child from camp.
(Do not forget to include yourself). Please print……

Full Name	Relationship	Cell Phone Number
Full Name	Relationship	Cell Phone Number
Full Name	Relationship	Cell Phone Number
Full Name	Relationship	Cell Phone Number
Full Name	Relationship	Cell Phone Number
Full Name	Relationship	Cell Phone Number
Full Name	Relationship	Cell Phone Number

Please list any person or a circumstance that you may want us to be aware of when bringing your child home. This should include but not be limited to an order of protection or anyone <u>not</u> authorized to pick up your child:

Parent/ Guardian Signature