HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent/guardian.)

Name of Program: _____

Child's Last Name: _____ Child's First Name: _____

Birthdate: ____/____/____ Sex: ☐ Male ☐ Female

Home Address:

Parent/Guardian: _____ Phone: (_____) _____

Place of Employment: Parent/Guardian #1: _____ Work Phone: (_____) _____

Parent/Guardian #2: _____ Work Phone: (_____) _____

In case of emergency, notify: _____ Phone: (_____) _____

If Parent, Guardian are not available in an emergency, notify: _____

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, giving approximate dates)

Ear Infection: _____ Hay Fever: _____ Measles: _____

Rheumatic Fever: _____ Ivy Poisoning, etc.: _____ German Measles: _____

Convulsion: _____ Insect Stings: _____ Mumps: _____

Diabetes: _____ Penicillin: _____ Other Contagious Illnesses: _____

Behavior: _____ Other Drugs: _____

Asthma: _____ Chicken Pox: _____

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 doctor: _____

Appliance worn (glasses, contacts, etc.): _____

Medication taken: _____

Suggestion from Parent/Guardian: _____

*****CONSENT FOR EMERGENCY MEDICAL TREATMENT*****

I do hereby give authority to the New York City's YMCA 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: _____

Date: _____ Phone: (_____) _____

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on opposite page.)

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 YMCA programs.

IMMUNIZATION HISTORY: This is a record of dates of basic immunization and most recent booster doses.

DTaP/Tdap/DTP/Td	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Polio	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
MMR	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Haemophilus influenzae type B (Hib)	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Hepatitis B	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Varicella	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Other:	Date: _____	Date: _____	Date: _____	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) **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: _____

Describe Abnormal 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 Afterschool and Youth Center activities, except as noted above.

Doctor's Stamp Here

Examining Physician (Signature): _____ Date of Examination: _____

Physician's Name (Please Print): _____

Address: _____ Zip Code: _____ Phone: (_____) _____