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

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

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| Name of Program: | | | |
| Child's Last Name: | | Child's First Name: | |
| Birthdate: | | Sex: ☐ Male ☐ Female | |
| Home Address: | | | |
| Parent/Guardian Name (Last, First): | | | 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: |
| Asthma: | Rheumatic Fever: | Mumps: |
| Diabetes: | Ivy Poisoning, etc.: | German Measles/Rubella: |
| Convulsion: | Insect Stings: | Chicken Pox: |
| Penicillin: | Behavior: | Other Contagious Illnesses: |
| Other Drugs: | | |
| Other Past Illnesses: | | |
| Serious Injuries/Hospitalization/Surgery (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, hearing aid, etc.): | | |
| Medication taken: | | |
| Is parent/guardian sending medication?: | | |
| Recommendations from Parent/Guardian: | | |

| *****CONSENT FOR EMERGENCY MEDICAL TREATMENT***** | |
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| 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. | | | | | |
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| DPT/DTaP | Date: | Date: | Date: | Date: | Date: |
| Polio (IPV or OPV) | Date: | Date: | Date: | Date: | |
| Haemophilus influenzae type B (Hib) | Date: | Date: | Date: | Date: | |
| Pnuemococcal Conjugate (PCV) | Date: | Date: | Date: | Date: | |
| Hepatitis B | Date: | Date: | Date: | | |
| Measles, Mumps, and Rubella (MMR) | Date: | Date: | | | |
| Varicella (also known as chicken pox) | Date: | Date: | | | |

| **Other Immunizations may include the recommended vaccines of Rotavirus, Influenza, and Hepatitis A** | | | |
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| Type of Immunization: | Date: | Type of Immunization: | Date: |

| **MEDICAL EXAMINATION:** Examination is acceptable when performed no more than 12 months prior to arrival at camp. | | | |
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| Code: | **S** = Satisfactory | **X** = Not Satisfactory (Explain) | **O** = Not Examined |
| **General Appearance:** | | | |
| Height: | Weight: | Blood Pressure: | Hgb. Test (Date): |
| HEENT: | Lymph nodes: | Abdomen: | Skin: |
| Dental: | Lungs: | Genitourinary: | Neurological: |
| Neck: | Cardiovascular: | Extremities: | Back/Spine: |
| Vision: | With Glasses: | Hearing: | |
| Describe Abnormal Findings and/or Handicapping Conditions: | | | |

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| Allergy (Specify): | Epi pen Prescribed: ☐ Yes ☐ No |
| Asthma (Specify condition): | Inhaler Prescribed: ☐ Yes ☐ No |
| Special Diet (Specify diet and condition): | |
| Medications taken (Specify drug and condition): | |
| Swimming: | Diving: |
| General Appraisal: | |
| Recommendations and restrictions while in camp: | |

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| On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is physically able to engage in Day Camp/Year-Round Afterschool/Youth Center Activities, except as noted above. | **Doctor's Stamp Here** |

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| Health Care Practitioner Signature: | | Date of Examination: |
| Health Care Practitioner Name (Print): | | Practitioner License No. and State: |
| Address: | Zip Code: | Phone: |