

**HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS**  
(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM Oasis in VAN CORTLANDT PARK

CHILD'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ BIRTHDATE  / / SEX M  F

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Employment: Father (Guardian) \_\_\_\_\_ Phone: \_\_\_\_\_  
Mother (Guardian) \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Phone: \_\_\_\_\_

If Parent, Guardian are not available in an emergency, notify:  
1. \_\_\_\_\_ Phone: \_\_\_\_\_  
or 2. \_\_\_\_\_ Phone: \_\_\_\_\_

**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 box if child has had afflictions, give appropriate dates)

Allergies

- |  |   |
|--|---|
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hay Fever _____        |
| <input type="checkbox"/> Seizures _____        | <input type="checkbox"/> Poison Ivy, etc. _____ |
| <input type="checkbox"/> Diabetes _____        | <input type="checkbox"/> Insect Stings _____    |
| <input type="checkbox"/> Asthma _____          | <input type="checkbox"/> Penicillin _____       |
| <input type="checkbox"/> Chicken Pox _____     | <input type="checkbox"/> Other Drugs _____      |
|  | <input type="checkbox"/> Food _____             |

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 Dr. \_\_\_\_\_

**Appliance worn (glasses, contacts, etc.)** \_\_\_\_\_

**Medication taken** \_\_\_\_\_

Suggestion from Parent/Guardian \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

*I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.*

Relationship \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ Tel.# \_\_\_\_\_

## PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

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 Day Camps and Afterschool and Youth Center programs.

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

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	Date _____

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**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)

0 = Not Examined

General Appearance \_\_\_\_\_

Genitalia \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Posture & Spine \_\_\_\_\_ Throat - Tonsils \_\_\_\_\_

Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Feet \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_

Hgb. Test (Date) \_\_\_\_\_ Urinalysis (Date) \_\_\_\_\_

Eyes \_\_\_\_\_ Vision \_\_\_\_\_ w/Glasses \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_

Ears \_\_\_\_\_ Hearing \_\_\_\_\_

Neurological Findings \_\_\_\_\_

Describe Abnormal Findings and/or Handicapping Conditions \_\_\_\_\_

Allergy: (Please specify) \_\_\_\_\_

Recommendations and restrictions while in camp:

Special Diet \_\_\_\_\_

Special Medicine (dose, route of administration, when should it be administered) \_\_\_\_\_

Is parent/guardian sending special medicine? \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

Swimming \_\_\_\_\_ Diving \_\_\_\_\_

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.

\_\_\_\_\_  
M.D.

EXAMINING PHYSICIAN (SIGNATURE)

\_\_\_\_\_  
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone \_\_\_\_\_ Address \_\_\_\_\_

Date of Examination \_\_\_\_\_

ZIP CODE