Parent completes this side of form
Physician completes reverse side

2018 CAMPER HEALTH FORM

Complete & Return form to:

Rockland Center for the Arts
Day Camp
27 South Greenbush Rd.
West Nyack, NY 10994

Telephone: (845) 358-0877
Fax: (845) 358-0971

PLEASE PRINT

Child's Name____ Birth Date____________ Sex ______ Age _______
Last First Initial

Home Address ____
Street & Number City State Zip Code

Parent / Guardian Name ________________________________Phone (home)________________Phone (work)______________

In an emergency, if parent / guardian is not available notify:

1. ____Phone (home)________________Phone (work)____________
Name

2. ____Phone (home)________________Phone (work)____________
Name

Child's Physician: ____ Phone (office) ____________________
Name

Health History: (Check all that apply)

		Allergies		**Disease**	
Ear Infections	______	Hay Fever	_______	Chicken Pox	______
Rheumatic Fever	______	Poison Ivy	_______	Measles	______
Convulsions	______	Insect Stings	_______	German Measles	______
Diabetes	______	Penicillin	_______	Mumps	______
Aspergers/Autism	______	Other Drugs (list)	_______	Asthma	______
Other Behavior Issues (list)	______				

Date of Most Recent Medical Examination ______________________ Examining Physician ____________________________

Operations & Dates ____

Chronic or Recurring Illness ____

Other Diseases or Details of Above____

List any Activities to be Restricted ____

IMPORTANT: **Please notify camp if this camper is exposed to any communicable disease during the 3 weeks prior to camp.**

PARENTS AUTHORIZATION
(Must be signed for admission to day camp)

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Parents / Guardian's Signature ________________________________Date ______

IMMUNIZATION HISTORY

Please list dates of basic immunizations and most recent booster doses.

DTP Series ______________________ **DPT Booster** _______________ **Tetanus Booster** ___________________

Polio OPC (Sabin) ________________ **Polio Booster** _______________ **Typhoid** __________________________

Measles Vaccine (live) _____________ **Measles Booster** ____________ **Tuberculin Test** ____________________

German Measles (Rubella)___________ **Mumps Vaccine (live)** ___________ **Haemophilus Influenza (hib)** ___________

Smallpox ________________________ **Hepatitis B** __________________ **Varicella(chicken pox)** ________________

MEDICAL EXAMINATION - To be filled out by a licensed physician

This examination should be performed within 12 months prior to arrival at camp. An examination for some other purpose within this period is acceptable. The examination is for determining fitness to engage in strenuous activities.

HEIGHT ________ **WEIGHT** __________ **B.P.** ____________ **HGB. TEST** ____________ **URINALYSIS** __________

EYES ______________________________ **EXTREMITIES** ___________________________

GLASSES ___________________________ **POSTURE (Spine)** _________________________

EARS ______________________________ **SKIN** ____________________________________

NOSE ______________________________ **ALLERGY: (Please Specify)**

THROAT ____________________________ **1.**___________________ **2.**_________________

HEART _____________________________ **GENERAL APPRAISAL:**

LUNGS _____________________________ ____

ABDOMEN __________________________ ____

HERNIA ____________________________

(FOR GIRLS AND WOMEN)

Has this person Menstruated? [ ] Yes [ ] No **If, not, has she been told about it?** [ ] Yes [ ] No

If so, is her menstrual history normal? [ ] Yes [ ] No **Special Considerations:** __________________________

RECOMMENDATIONS & RESTRICTIONS WHILE IN CAMP:

Diet Restrictions: ____

Special Medicine (name it) _____________________________ **Is Parent Sending It?** ____________________________________

Is Swimming or Diving restricted? ____

Is Strenuous Activity restricted? ____

Other ____

I have examined the person herein described & have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

____________________________________ Address ____

Signature of Examining Physician

Phone ____