Parent completes this side of form
Physician completes reverse side

2021 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.

____
Signature of Examining Physician

Address ____

Phone ____