

Parent completes this side of form
Physician completes reverse side

2020 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)

	<u>Allergies</u>	<u>Disease</u>
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 _____