DAY CAMP IN THE PARK **HEALTH FORM** **6 Kendall Dr, New City, NY 10956**

To be completed by camper's physician **Physical Examination must be after Aug. 18, 2016**

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	☐	☐	12. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	13. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
3. Ever been hospitalized?	☐	☐	14. Have diabetes?	☐	☐
4. Ever had surgery?	☐	☐	15. Have asthma?	☐	☐
5. Ever been dizzy during or after exercise?	☐	☐	16. Ever had high blood pressure?	☐	☐
6. Ever pass out during or after exercise?	☐	☐	17. Ever had seizures?	☐	☐
7. Ever been knocked unconscious?	☐	☐	18. Ever had a head injury?	☐	☐
8. Ever been diagnosed with a heart murmur?	☐	☐	19. Have frequent headaches?	☐	☐
9. Ever had chest pain during or after exercise?	☐	☐	20. Wear glasses, contacts or protective eye wear?	☐	☐
10. Ever had frequent ear infections?	☐	☐			
11. Ever had back problems?	☐	☐			

Please explain any "yes" answers, noting the number of the question.

_____

_____

IMMUNIZATION RECORD Please attach an immunization record that includes the dates, vaccine. DPT, TD, MMR, Hep, etc.

ALLERGIES List all known: Describe reaction and management of the reaction

Medication allergies (list)

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

Other allergies (list) Include insect stings, hay fever, asthma, etc.

_____ _____

_____ _____

MEDICATION BEING TAKEN Please list **ALL** medications (prescription and over-the-counter) taken routinely.

This person takes medication as follows:

Med. #1_____Dosage_____Specific times taken each day_____

Med. #2_____Dosage_____Specific times taken each day_____

Identify any medications taken during the school year that participant does/may not take during the summer:

Medication not taken in the summer:_____

RESTRICTIONS Explain any restrictions to activity (e.g., what cannot be done, or limitations necessary)

_____

_____

IMMUNIZATION RECORD Please attach a copy of the participant's immunization record that includes the dates, and vaccines. DPT, TD, Tetanus, Polio, Measles, Rubella, Hepatitis B

PHYSICAL EXAMINATION I have examined the above camp participant. Date of examination_____

Height_____Weight_____BP_____Vision_____Glasses_____ Hernia_____

Ears_____ Any known loss_____ Urine analysis_____ Tuberculin Test_____

In my opinion, the above applicant☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: _____

Signature of Physician_____Date_____

Physician's address_____Telephone_____