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 _____

_____ (CHILD'S LAST NAME) _____ (FIRST NAME) ___/___/___ (BIRTHDATE) M ❑ F ❑ (SEX)

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)

- ❑ Rheumatic Fever _____
- ❑ Seizures _____
- ❑ Diabetes _____
- ❑ Asthma _____
- ❑ Chicken Pox _____

Allergies

- ❑ Hay Fever _____
- ❑ Poison Ivy, etc. _____
- ❑ Insect Stings _____
- ❑ Penicillin _____
- ❑ Other Drugs _____
- ❑ 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.# _____