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 UNITED AQUATIC SPORTS **Permit No. 85** _____

_____ _____ ___/___/___ ☐ M ☐ F

CHILD'S LAST NAME | FIRST NAME | BIRTHDATE | 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, giving approximate dates)

Ear Infections _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Ivy Poisoning, etc. _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Other Contagious Illnesses _____
Asthma _____		

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 herby 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 _____ Tele.# _____

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center Programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DpaP, DTP or TD	Date		Date		Date		Date		Date
Polio\	Date		Date		Date		Date		Date
MMR\	Date		Date		Date		Date		Date
Hemophilus Influenzae type b	Date		Date		Date		Date		Date
Hepatitus B	Date		Date		Date		Date		Date
Varicella	Date		Date		Date		Date		Date
Other							Date		Date

MEDICAL EXAMINATION – To be filled out by licensed physician

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory X = No Satisfactory (Explain) 0 = Not Examined

General Appearance _____

Height _____ Weight _____ Blood Pressure _____ Hgb. Test (Date) _____

Urinalysis (Date) _____ Posture & Spine _____ Throat – Tonsils _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____ Feet _____ Lungs _____ Skin _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____

Genitalia _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

Has child ever received products containing horse serum? _____

Allergy: (Please specify) _____

Recommendations and restrictions while in camp.

Special Diet _____

Special Medicine (name it) _____

Is parent/guardian sending special medicine? _____

Swimming _____ Diving _____

Activity Restrictions _____

General Appraisal: _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

_____ M.D.

EXAMINING PHYSICIAN (SIGNATURE)

_____

PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____

ZIP CODE