

Physician's Report

Summer of 2011



P.O. Box 34
 Merrick, NY 11566
 516-620-4300
 Fax 516-620-4329

The camper's physician must complete both sides of this form. Please return to the camp office by April 15th. All information will be held in the strictest confidence; please be as thorough as possible.

Child's name Date of Birth

Date Weight Height

Blood Pressure Urine Hematocrit

Health Care Recommendations by Licensed Physician

I have examined the child within the past year. Date examined

The NY Department of Health requires that a physical exam was completed no more than a year prior to the last day of camp, August 19.

Is the camper able to participate in an active camp program? Yes No

Camper is under the care of a physician for the following condition(s):

.....

Current treatment (include current medications):

.....

Explanation of any reported loss of consciousness, convulsion, or concussion:

.....

Are there any...

Allergies (food, drugs, plants, insects, etc.)?

If yes, should exposure occur, how should the allergic reaction be treated? If this is an anaphylactic response, will this child's parents supply an epinephrine device?

.....

Cardiovascular conditions?

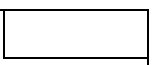
Respiratory conditions?

Middle ear conditions?

Gastrointestinal conditions?

Please complete both sides of this form.

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Child's Name

Are there any...

Activity restrictions?

Neurological conditions?

Orthopedic conditions?

Special diet?

Treatment(s) to be continued at camp?

Medication(s) to be administered at camp?

 Same as during the school year?

Additional medical or psychological conditions not listed that we should be aware of?

Camper Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT Series, Diphtheria, Pertussis, Tetanus OR	1 2 3	1 2 3
TD Series, Tetanus, Diphtheria OR Tetanus		
Polio Series		
MMR Series		
HIB Series		
Hepatitis B Series		
Chicken Pox (illness or vaccine)		
Meningitis		
Other		

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments. Thank you for helping us to provide a successful summer experience for this camper!

Licensed Physician's Signature.....

Physician's Printed Name.....

Physician's Address
Street
City, State, Zip
Phone.....
Area Code/Number

Date of Form Completion *By
*Initial if completed by nurse or physician's assistant.