

**PARK SHORE COUNTRY DAY CAMP  
HEALTH INFORMATION - SUMMER 2021**



**MUST BE COMPLETED & RECEIVED PRIOR TO CAMP**

The information on this form is to assist us in planning appropriate care. Updates should be provided to the office as they occur.

Child's Name \_\_\_\_\_  
Last First Middle

Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_ Present Grade (2020 - 2021) \_\_\_\_\_ Gender \_\_\_\_\_

Home address \_\_\_\_\_ Primary phone \_\_\_\_\_  
Street address City Zip

Father's Name \_\_\_\_\_ Home address \_\_\_\_\_  
(if different from above)

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home address \_\_\_\_\_  
(if different from above)

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact (Other than parents)	Relationship	Home/Work/Cell Phone
_____	_____	_____
_____	_____	_____

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, animal dander, etc.

\_\_\_\_\_

\_\_\_\_\_

**Restrictions** (The following restrictions apply to this individual.)

Food: Red meat \_\_\_ Pork \_\_\_ Dairy Products \_\_\_ Poultry \_\_\_ Fish/Seafood \_\_\_ Eggs \_\_\_ Other (describe) \_\_\_\_\_

**Activity Restrictions:** (e.g. What accommodations or limitations are necessary?)

\_\_\_\_\_

*IN THE EVENT THAT I OR MY CONTACTS CANNOT BE REACHED IN AN **EMERGENCY**, I HEREBY GIVE MY PERMISSION TO PARK SHORE, THE LOCAL AMBULANCE/FIRE DEPARTMENT, MY FAMILY PHYSICIAN, ANY LOCAL PHYSICIAN, OR THE NEAREST HOSPITAL TO ADMINISTER EMERGENCY TREATMENT AND CARE. I FURTHER GIVE MY PERMISSION FOR ALL PERTINENT HEALTH INFORMATION TO BE DUPLICATED AND RELEASED TO THE APPROPRIATE PERSONNEL FOR EMERGENCY CARE.*

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Signature/Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY PARENT/LEGAL GUARDIAN**  
**MEDICATIONS**

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the child's name, the prescribing physician (if a prescription drug,) the name of the medication, the dosage, route, and the frequency of administration. Ensure that medications are not expired. A **Medication Administration Form** (this form can be downloaded from our website) ***MUST accompany all medications to be administered, routine or on an 'as needed' basis.***

This person <b>takes NO medications</b> on a routine basis. OR ___ This person <b>takes medications</b> as follows:		
Med #1 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Med #2 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		

**GENERAL QUESTIONS** (Explain "yes" answers below)

Has/does the participant?	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?			15. Ever been diagnosed with a heart murmur?		
2. Have a chronic or recurring illness/condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints (e.g. knees, ankles)?		
4. Ever had surgery?			18. Have an orthodontic appliance being brought to camp?		
5. Have frequent headaches?			19. Have any skin problems (e.g. itching, rash, acne)?		
6. Ever had a head injury?			20. Have diabetes?		
7. Ever been knocked unconscious?			21. Have asthma?		
8. Wear glasses, contacts, or protective eyewear?			22. Had mononucleosis in the past 12 months?		
9. Ever had frequent ear infections?			23. Had problems with diarrhea/constipation?		
10. Ever passed out during or after exercise?			24. If female, have an abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			25. Have a history of bed-wetting?		
12. Ever had seizures?			26. Ever had an eating disorder?		
13. Ever had chest pain during or after exercise?			27. Ever had emotional difficulties for which professional help was sought?		
14. Ever had high blood pressure?			28. Have Additional Health Concerns?		

Please explain any "yes" answers, noting the number of the questions: \_\_\_\_\_  
 \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**SEE ATTACHED FOR ANNUAL MEDICAL FORMS** – TO BE COMPLETED BY PHYSICIAN

The Department of Health regulations require a complete ANNUAL physical exam in order to attend & participate in camp. Please have your physician complete the attached form: annual physical exam & Immunizations/vaccinations.

**FOR HEALTH OFFICE USE ONLY**

PROFILE: \_\_\_\_\_

ANNUAL PHYSICAL EXAM: \_\_\_\_\_

IMMUNIZATION/VACINATION RECORD: \_\_\_\_\_

FANE REPORT: \_\_\_\_\_

ENTER COMPUTER: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Park Shore Country Day Camp**

**450 Deer Park Road**

**Dix Hills, NY 11746**

**631-499-8580**

**Email: [sue@parkshoredaycamp.com](mailto:sue@parkshoredaycamp.com)**

**\*\*\*MUST BE COMPLETED BY PHYSICIAN ANNUALLY OR  
PROVIDE PHYSICIAN'S ANNUAL PHYSICAL EXAM & IMMUNIZATION HEALTH HISTORY FORM**

Which of the following has the participant had?

- Measles                     Hepatitis A  
 Chicken Pox                 Hepatitis B  
 German measles            Hepatitis C  
 Mumps                         Other

TB Test: Date of last test \_\_\_\_\_

Results:  positive  negative

\*Height \_\_\_\_\_ \*Weight \_\_\_\_\_

\*Blood Pressure \_\_\_\_\_ \*Pulse \_\_\_\_\_

Please give all dates of immunization for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP						
Tdap						
Tetanus						
Polio (OPV/IPV)						
MMR or Measles or Mumps or Rubella						
Haemophilus influenza B						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Pneumococcal vaccine						
Meningococcal vaccine						

**\*REQUIRED BY PHYSICIAN**

I have examined the above child and in my opinion, the above child's condition DOES \_\_\_\_\_ DOES NOT \_\_\_\_\_ preclude his/her participation in an active camp program. (Include Physician or Health Care Provider's stamp)

\_\_\_\_\_  
**Licensed Physician's Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_