HEALTH FORM 2018

PARK SHORE COUNTRY DAY CAMP
450 Deer Park Road, Dix Hills, NY 11746-5205
Phone # (631) 499-8580 * Fax # (631) 499-6917

MUST BE COMPLETED PRIOR TO CAMP BY PARENT OR GUARDIAN

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

Camper's Name _____
Last First Middle

Birth date _____ Age at camp _____ Present Grade (2017 - 2018) _____ Sex _____

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.*

Signature of Parent/Legal Guardian Date

In order to better accommodate your child's needs; does your child receive special services in school or anywhere else? _____ Yes _____ No

If yes, please explain. _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

MEDICATIONS BEING TAKEN

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 MUST accompany all medications to be administered, routine or on an 'as needed' basis.*

This person **takes NO medications** on a routine basis. OR ___ This person **takes medications** 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: _____

_____

MUST BE COMPLETED BY PHYSICIAN OR PROVIDE PHYSICIAN'S PHYSICAL/EXAM/IMMUNIZATIONS/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 PHYSCIAN**

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's or Health Care Provider's stamp)

_____

Licensed Physician's Signature Print Name Date

Address _____ Phone _____

Name of familydentist/orthodontist_____

Address _____ Phone _____