

**CAMP HEALTH FORM**

Camper # \_\_\_\_\_

Return To: *Magic Carpet Day Camp*  
P.O. Box 171  
Fort Tilden, NY 11695



(718) 634-8109

(718) 318-3609 FAX

**PHYSICAL EXAMINATION**

(To be filled out by Physician and returned by May 1<sup>st</sup>)

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 Magic Carpet Day Camp.

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M  F   
Gender \_\_\_\_\_ Birth Date \_\_\_\_\_  
Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Full Name (Relationship to Child)

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

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenza type b (HIB)	Date _____	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	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 = Not Satisfactory (Explain)  
O = Not Examined

General Appearance \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Posture & Spine \_\_\_\_\_  
Urinalysis (Date) \_\_\_\_\_ Hgb. Test (Date) \_\_\_\_\_ Throat - Tonsils \_\_\_\_\_  
Eyes \_\_\_\_\_ Vision \_\_\_\_\_ w/Glasses \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_  
Ears \_\_\_\_\_ Hearing \_\_\_\_\_ Feet \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_  
Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_  
Genitalia \_\_\_\_\_  
Allergy: (Please specify) \_\_\_\_\_  
Neurological Findings \_\_\_\_\_  
Describe Abnormal Findings and/or Handicapping Conditions \_\_\_\_\_

Has child ever received products containing horse serum? \_\_\_\_\_

**Recommendations and restrictions while in camp:**

Special Diet \_\_\_\_\_  
Medications (list names, dose, route of administration, when should it be administered) \_\_\_\_\_  
Medications to be given in camp (list) \_\_\_\_\_  
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 activities, except as noted above.

\_\_\_\_\_  
EXAMINING PHYSICIAN (SIGNATURE) M.D.

\_\_\_\_\_  
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone \_\_\_\_\_ Address \_\_\_\_\_

Date of Examination \_\_\_\_\_ ZIP CODE \_\_\_\_\_