CAMP HEALTH FORM

Staff Form

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

Return of this form is requested by May 15th

718-634-8109
Fax: 718-318-3609

This side to be filled in before presentation to physician.

Last Name ________ **First Name** ________ **Birthdate** ________ **Sex** ________

Home Address: ____________________ **Phone:** ________
Name of Parents or Spouse: ____________________ **Phone:** ________
Place of Employment: Spouse: ____________________ **Phone:** ________
Father: ____________________
Mother: ____________________ **Phone:** ________
In case of emergency, notify: ____________________ **Phone:** ________
If Parent or Spouse are not available in an emergency, notify: (Family Physician)
1. ____________________ **Phone:** ________
or 2. ____________________ **Phone:** ________

Important: Please notify the camp if you are 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)

	Allergies	Diseases
Ear Infections ________	Hay Fever ________	Chicken Pox ________
Rheumatic Fever ________	Ivy Poisoning ________	Measles ________
Convulsion ________	Insect Stings ________	German Measles ________
Diabetes ________	Penicillin ________	Mumps ________
Behavior ________	Other Drugs ________	Asthma ________

Past Illnesses: ____________________ **Contagious Illnesses:** ____________________
Operations or Serious Injuries (Dates) ____________________
Hospitalization (Dates) ____________________
Chronic or Recurring Illnesses ____________________
Other Diseases or Details of Above ____________________
Any specific activities to be encouraged? ____________________
To be restricted? ____________________
Permission for all program activities unless otherwise noted by Dr. ____________________

SIGNIFICANT HEALTH HISTORY
CURRENT CONDITIONS

Please List

Medication Taken ____________________
Appliance Worn (Glasses, etc.) ____________________
Conditions Which Modify Activity (Seizures, Amnesia, Heart Conditions, etc.) ____________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp Staff to obtain necessary emergency medical treatment for myself/my child with the understanding that the family will be notified as soon as possible.

Signature ____________________ **Date** ________ **Tele. #** ____________________
(Staff Signature if over 18/Parent Signature if under 18)

Name of Staff Member ______________________________

PHYSICAL EXAMINATION

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

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

DPT or DT or TD Date ________ Date ________ Date ________ Date ________ Date ________

Polio Date ________

Measles Date ________

Rubella Date ________

Mumps Date ________ **Tuberculin Test Given** ______________ **(most recent)**

MEDICAL EXAMINATION - To be filled out by licensed physician.

This examination should be performed within 12 months of arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
O = Not Examined

General Appearance ______________________________

Height ________ **Weight** ________ **Blood Pressure** ________ **Hgb. Test** ________

Urinalysis ________ **Posture & Spine** ________ **Throat - Tonsils** ________

Eyes ________ **Vision** ________ **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 applicant ever received products containing horse serum? ______________________________

Recommendations and restrictions while in camp.

Special Diet ______________________________

Special Medication taken (name it) ______________________________

Will this medication be taken in camp? ______________________________

Swimming ______________________________

Strenuous Activity: ______________________________

General Appraisal: ______________________________

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____

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.

______________________________**M.D.**

EXAMINING PHYSICIAN

Telephone ______________________________ **Address** ______________________________

Date of Examination ______________________________ ______________________________

ZIP CODE