HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

_____ (CHILD'S LAST NAME) _____ (FIRST NAME) ___/___/___ (BIRTHDATE) M☐ F☐ (SEX)

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes ☐ No ☐ (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

- ☐ Rheumatic Fever _____
- ☐ Seizures _____
- ☐ Diabetes _____
- ☐ Asthma _____
- ☐ Chicken Pox _____

Allergies

- ☐ Hay Fever _____
- ☐ Poison Ivy, etc. _____
- ☐ Insect Stings _____
- ☐ Penicillin _____
- ☐ Other Drugs _____
- ☐ Food _____

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____

PHYSICAL EXAMINATION

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

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 Day Camps and Afterschool and Youth Center programs.

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 Influenzae type b (Hib)		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)
0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

_____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

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/Year Round Afterschool and Youth Center activities, except as noted above.

_____ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____
ZIP CODE

Standing Orders for Over the Counter & Prescription Medications

Bronx House Day Camp – Unit:_____

The Rockland County Department of Health requires individualized standing orders for each camper for the camp's health care staff to follow in administering both over the counter medications and prescription medications. Please complete no more than 6 months prior to the start of camp.

Camper's Name: _____ DOB: ___/___/___ Age: ____ Gender: __M__F Weight: _____

These medications are stocked in the camp infirmary. Parents don't need to send these to camp. Dosing will be per label instructions and/or using age/weight dosage calculations and administered only after assessment by Registered Nurse.

Medication	Route *(please circle preferred formulation(s)*	Dosage	Schedule and Indications	Camper Healthcare Provider Order	Comments
Benadryl	PO (elixir or chewable tabs)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction	Yes / No	
Advil, Motrin (Ibuprofen)	PO (elixir or chewable tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever >_____°F	Yes / No	
Tylenol (Acetaminophen)	PO (elixir or chewable tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever >_____°F	Yes / No	
Children's Robitussin DM	PO (elixir)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes / No	
Robitussin	PO (elixir)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes / No	
Pepto Bismol	PO (elixir)	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)	Yes / No	
Neosporin Ointment	PO (ointment)	Per label instructions by age/weight	Q 1 to 3 times a day.	Yes / No	
Hydrocortisone (1% cream)	PO (ointment)	Per label instructions by age/weight	Q up to 4 times daily for skin irriation (e.g. insect bites, rash)	Yes / No	
Aloe or Burn Spray/Gel	PO (spray or gel)	Per label instructions by age/weight	Q as indicated on package	Yes / No	

Physician: List any additional over the counter medications (including vitamins) and/or prescription medications as ordered that the camper will be taking on an as needed or daily basis. All medication must be in the original labeled container and given to the infirmary staff. These medications will be kept in the infirmary during the camper's entire stay.

Medication	Route	Dosage	Schedule and Indications	Comments

Health Care Provider's Name:_____

Physician's Signature:_____

Date:_____ Office Phone #:_____

I agree with the above orders as signed by my child's physician (parent signauture):_____