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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
<th>Date 4</th>
<th>Date 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT or DT or TD</td>
<td>Date 1</td>
<td>Date 2</td>
<td>Date 3</td>
<td>Date 4</td>
<td>Date 5</td>
</tr>
<tr>
<td>Polio</td>
<td>Date 1</td>
<td>Date 2</td>
<td>Date 3</td>
<td>Date 4</td>
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<tr>
<td>Measles</td>
<td>Date</td>
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<tr>
<td>Rubella</td>
<td>Date</td>
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<td></td>
<td>(PPD-MANTOUX) Date Read</td>
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<tr>
<td>Mumps</td>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculin Test Given (most recent) Result</td>
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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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>Hgb. Test</th>
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Urinalysis | Posture & Spine | Throat - Tonsils | Vision | Glasses | Extremities | Heart | Hearing | Feet | Lungs | Skin |
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Eyes | Vision | Glasses | Extremities | Heart |
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Ears | Hearing | Feet | Lungs | Skin |
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Nose | Teeth | Abdomen | Hernia |
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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
Special Medicine (name it)
Is parent/guardian sending special medicine?
Swimming | Diving
Strenuous Activity

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

OCR7 (Rev. 2/94)
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
MO FO
SEX

Home Address:

Parent or Guardian:

Place of Employment: Father
Mother

In case of emergency, notify:

If Parent, Guardian are not available in an emergency, notify: (Family Physician)

1. 
2. 

Important: Please notify the camp if this camper is 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

Ear Infections
Rheumatic Fever
Convulsion
Diabetes
Behavior

Hay Fever
Ivy Poisoning, etc.
Insect Stings
Penicillin
Other Drugs

Diseases

Chicken Pox
Measles
German Measles
Mumps
Asthma

Past Illnesses

Contagious Illnesses

Operations or Serious Injuries (Dates)

Hospitalization (Dates)

Chronic or Recurring Illness

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.

Suggestion from Parent/Guardian

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 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
Tele.#

Department of Health
The City of New York
Day Camps & Recreation Unit

DCR7 (Rev. 7/94)