SYJCC 74 HAUPPAUGE RD. COMMACK, NY 11725 (631) 462-9800

TWEENS CAMPER HEALTH INFORMATION FORM

(Note:This side to be completed by parent, **notarized** and returned to SYJCC office 1 month before the start of camp.)

_________________________ _________________________ _____ _____________ ____ ________

Camper's Last Name **First Name** Sex Date of Birth Age Grade (as of Sept.)

Address___________________________________Town//Zip_______________ Home Phone ____________________

Parent 1/Guardian:_____________________________Work Number: ______________Cell Phone:________________

Parent 2/Guardian:____________________________Work Number:______________Cell Phone:_________________

Email Address:____

Emergency Name #1 __________________________ Emergency Phone_____________________________________

Emergency Name # 2 ______________________ Emergency Phone ____

Family Physician, Name_____________________Telephone Number___________________________________

HEALTH HISTORY: (Check - give approximate dates)

_____Frequent Colds______Abscessed Ears _____Fainting_____Stomach Upsets_____Athlete's Foot ______Sinusitis
_____T.B. _____Bronchitis _____Motion Sickness_____Convulsions_____Whooping Cough_____ Polio_____ Poison Ivy
_____Rheumatic Fever_____Heart Trouble _____Diabetes_____ Poison Oak/Sumac

Has daughter menstruated? ________ Has she been told about it? _________

Operations, Serious illnesses or injury, explain.____

Any specific activities to be encouraged____

Any specific activities to be restricted____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. If camper needs medication during camp hours, keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. A doctor's note and Parent's note will also be required.

☐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____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during this summer:________

____

IMPORTANT: Please notify the camp if your child was exposed to any communicable diseases during the **3 weeks prior** to camp attendance.

AUTHORIZATION FOR EMERGENCY MEDICAL SURGICAL TREATMENT

NOTE: It is the firm hope that the authorization granted on this form will never have to be used. However, for the safety of your child, sound medical practice calls for such authorization. In emergency situations where for some reason, the parent cannot be contacted immediately, this form may be extremely important. Doctors and hospitals refuse to give any treatment, regardless of how minor, unless they have a notarized authorization from a parent.

THE AUTHORIZATION GRANTED BY THIS FORM WILL BE USED ONLY WHEN ABSOLUTELY NECESSARY AND ONLY AFTER EVERY ATTEMPT HAS BEEN MADE TO CONTACT A PARENT.

I understand that in the event I cannot be reached, I hereby give permission to the physician or hospital selected by the SYJCC camp administration to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

____ ____________________ **Signature of Parent/Guardian** **(Must sign in front of Notary)** **Date**

Notary: _________________________________ _________________________________ **Date**

(Please have your physician fill out and sign the reverse side of this form before returning it to the SYJCC Office. Thank you.)

PHYSICAL EXAMINATION

Camper's Name________________________________ **TWEENS CAMP PROGRAM**

Date of Examination__________________________ (To be completed by a Licensed Physician)

Code: __________ Satisfactory:______________Not Satisfactory (please explain) ______________________

Hgt. ____________ Blood Pressure __________ Eyes ____________ Glasses? __________Wgt. ______

Hgb. Test Done: __________ Urine Analysis Test Done? __________Ears __________ Extremities ______

Nose ___________ Posture (spine) ____________Throat __________ Skin ____________ Heart ______

Genitalia ______________General Appraisal: ____

Lungs ___________ Hernia ___________ Abdomen ___________ Menstrual History ___________

Recommendations and/or restrictions (diet, medicine, swimming, diving, etc.)______________________

____

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.

______________________ ____

______________________ ____

IMMUNIZATIONS: PLEASE ENTER DATES (State law requires dates to be entered)

Which of the following has the participant had?	Please give all dates of immunization for: Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
☐ Measles	DTP	____	____	____	____	____	____
☐ Chicken pox	TD (tetanus/diphtheria)	____	____	____	____	____	____
☐ German measles	Tetanus	____	____	____	____	____	____
☐ Mumps	Polio	____	____	____	____	____	____
☐ Hepatitis A	MMR	____	____	____	____	____	____
☐ Hepatitis B	Or Measles	____	____	____	____	____	____
☐ Hepatitis C	Or Mumps	____	____	____	____	____	____
	Or Rubella	____	____	____	____	____	____
TB Mantoux test	Haemophilus influenza B	____	____	____	____		
Date of last test________	Hepatitis B	____	____	____			
Result: ☐ Positive ☐ Negative	Varicella (chicken pox)	____	____				

______________________________ ______________________________

Signature of Examining Physician

______________________________ ______________________________

Telephone Number

______________________________ ______________________________

Date of Examination Physician's Stamp

(Reverse side to be completed by Parent)