

## Health History Form - Summer Camp 2021 (This side to be filled in by parent before presentation to physician)

CHILD'S LAST NAME  Home Address:  Phone:  Phone:  Phone:  Phone:  Phone:  Mother (Guardian)  Mother (Guardian)  Phone:  Phone:  Phone:  Mother (Guardian)  Phone:  Or 2.  Phone:  Phone:  Phone:  Phone:  Phone:  Or 2.  Phone:  Phone					/	/	М	F□
Parent or Guardian: Phone: Phone: Phone: Phone: Phone: Mother (Guardian) Phone:	CHILE	D'S LAST NAME F	IRST NAME		BIRTHD	ATE	SE	X
Place of Employment: Father (Guardian) Phone:    Mother (Guardian) Phone:	Home Address:			P	hone: _			
Mother (Guardian) Phone: Phone	Parent or Guardi	an:		P	hone:			
Mother (Guardian) Phone: Phone	Place of Employ	ment: Father (Guardian)		PΙ	none: -			
In case of emergency, notify:	race of Employ							
If Parent, Guardian are not available in an emergency, notify:    1.	In case of emerg				none: -			
1. Phone:  Phone:  Phone:  Phone:  HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)  Allergies  Rheumatic Fever   Hay Fever     Poison Ivy, etc.     Diabetes   Insect Stings     Asthma   Penicillin     Chicken Pox   Other Drugs     Food    Other Past Illnesses  Operations or Serious Injuries (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 authorize that all of the above information is correct and that my child is fully able to participate in all Science Museum of Long Island Summer Camp Activities. I agree to notify SMLI of any changes in my child's physical or mental health between the dates of enrollment and the start of camp as well as during camp.								
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Seizures   Poison Ivy, etc.     Diabetes   Insect Stings     Asthma   Penicillin     Chicken Pox   Other Drugs     Food     Food     Other Past Illnesses     Departions 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 authorize that all of the above information is correct and that my child is fully able to participate in all Science     Museum of Long Island Summer Camp Activities. I agree to notify SMLI of any changes in my child's physical or mental health between the dates of enrollment and the start of camp as well as during camp.		OK1. (Check box if clind has had affliction						
Diabetes   Insect Stings   Penicillin   Penicillin   Other Drugs   Food		Rheumatic Fever	_ □	Hay Fever				
Asthma Other Drugs Other Drugs Food Other Past Illnesses Operations or Serious Injuries (Dates) Hospitalization (Dates) On the require 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 authorize that all of the above information is correct and that my child is fully able to participate in all Science Museum of Long Island Summer Camp Activities. I agree to notify SMLI of any changes in my child's physical or mental health between the dates of enrollment and the start of camp as well as during camp.		Seizures	_ □	Poison Ivy, etc.				
Chicken Pox		Diabetes	_ □	Insect Stings				
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 authorize that all of the above information is correct and that my child is fully able to participate in all Science Museum of Long Island Summer Camp Activities. I agree to notify SMLI of any changes in my child's physical or mental health between the dates of enrollment and the start of camp as well as during camp.		Asthma	_ 🗆	Penicillin				
Other Past Illnesses		Chicken Pox	_ □	Other Drugs _				
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 authorize that all of the above information is correct and that my child is fully able to participate in all Science Museum of Long Island Summer Camp Activities. I agree to notify SMLI of any changes in my child's physical or mental health between the dates of enrollment and the start of camp as well as during camp.				Food				
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	Relationship			•		-		

## PHYSICAL EXAMINATION

(<u>To be filled out by Physician – please note information on reverse side</u>)

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.

Hgb. Test (Date)		HICTORY TO .		The state to the state of the s				
Polio Date Date Date Date Date Date Date Date								
MMR Date Date Date Date Date Date Date Date								
Hemophilus Influenzae type b (Hib) Date Date Date Date Date Date Date Date							Date	
Hepatitis B Date Date Date Date Date Date Date Date							Date	
Varicella Date Date Pneumococcal Conjugate (PCV) Date Date Date Date Date Date Date Date	=							
Pneumococcal Conjugate (PCV) Date Date Date Date Date Date Date Date	•				Date			
Conjugate (PCV) Date Date Other D		<u></u>		<del></del>				
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  Height	Conjugate (PCV)	Date	_ Date	Date	Date		Date	
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  Height	Other	Date	Other	Date	Othe	r	Date	
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  Height Weight Blood Pressure Posture & Spine Throat - Tonsils	MEDICAL EXAMIN	NATION – To be fill	ed out by licensed p	hysician.				
X = Not Satisfactory (Explain) 0 = Not Examined  General Appearance				-	arrival at cam	p.		
X = Not Satisfactory (Explain) 0 = Not Examined  General Appearance	Code: $S = Sa$	atisfactory		_				
General Appearance  Height Weight Blood Pressure Posture & Spine Throat - Tonsils		•	ain)					
Height Weight Blood Pressure Posture & Spine Throat - Tonsils		• •	•					
Height Weight Blood Pressure Posture & Spine Throat - Tonsils	General Appearance							
Nose Teeth Abdomen Hernia Feet Lungs Skin  Hgb. Test (Date) Urinalysis (Date) Eyes Vision w/Glasses Extremities Heart  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 Summer Camp Activities, except as noted above.  M.D.  EXAMINING PHYSICIAN (SIGNATURE)  PHYSICIANS NAME (PLEASE PRINT)  Telephone Address								
Hgb. Test (Date)	•	•			-			
Eyes					_ Feet	Lungs	Skin	
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 Summer Camp Activities, except as noted above.  M.D.  EXAMINING PHYSICIAN (SIGNATURE)  PHYSICIAN'S NAME (PLEASE PRINT)  Telephone Address			•					
Neurological Findings	•		Glasses	_ Extremities		_ Heart		
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 Summer Camp Activities, except as noted above.  M.D.  EXAMINING PHYSICIAN (SIGNATURE)  PHYSICIANS NAME (PLEASE PRINT)  Telephone Address		=						
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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 Summer Camp Activities, except as noted above.  M.D.  EXAMINING PHYSICIAN (SIGNATURE)  PHYSICIAN'S NAME (PLEASE PRINT)  Telephone  Address	Special Diet _							
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Telephone Address	engage in Summer C	Camp Activities, exce	ept as noted above.					
Telephone Address								MD
Telephone Address					EXAM	INING PHYSICIA	AN (SIGNATURE)	M.D.
Telephone Address							,	
					PHY	SICIAN'S NAME	(PLEASE PRINT)	
	Telephone		Address					
	Date of Examination							

ZIP CODE