Museum of Long Island

# Health History Form - Summer Camp 2021

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

| CHILD'S LAST NAME | FIRST NAME | BIRTHDATE | SEX |
|---|---|---|---|
| | | / / | M ❑ F ❑ |

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: _____

**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 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.**

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 _____

_____

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 Summer Camp Activities, except as noted above.

_____ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____
ZIP CODE