USDAN SUMMER CAMP FOR THE ARTS

a beneficiary of UJA Federation of New York Good together.

HEALTH FORM

Child's Name _____

PHYSICAL EXAMINATION (This side is to be filled out by physician) DATE OF EXAM_____

General appearance: _____

Height: _____ Eyes: _____ Nose: _____

Weight: _____ Vision: _____ Throat-tonsils: _____

Posture & Spine: _____ Glasses/Contacts: _____ Abdomen: _____

Feet: _____ Ears: _____ Hernia: _____

Skin: _____ Hearing: _____ Genitalia: _____

Blood Pressure: _____ Teeth: _____ Neurological Findings: _____

Lungs: _____ Heart: _____ Other: _____

Describe abnormal findings and/or handicapping conditions:

_____

_____

List allergies or current medications:

_____

_____

Any restriction as to: Swimming: _____ Diving: _____ Other: _____

Immunization Records	Dates				
DPT					
Polio					
Measles/Mumps/Rubella					
Hepatitis B					
Varivax					
Haemophilus B (HIB)					
Meningitis:					
Other:					

PLEASE SIGN AND DATE PAGE 2.

BUSINESS OFFICE 420 East 79th Street, New York, NY 10075 | Phone: 212-772-6060

CAMP 185 Colonial Springs Road, Wheatley Heights, NY 11798 | Phone: 631-643-7900 | Fax: 631-643-6309

WWW.USDAN.ORG

MEDICATIONS

For pain &/or fever > 100°F: Children's Motrin: ___mg q6h OR Children's Tylenol: ___mg q4h

For hives/allergic reactions: Children's Benadryl- q6h: __12.5mg __18.75mg __25mg __31.25mg __ 37.5mg ___43.75mg ___50mg___

Prescription Medications To Be Taken During Camp

NAME: _____ **DOSAGE/TIME:** _____

NAME: _____ **DOSAGE/TIME:** _____

NAME: _____ **DOSAGE/TIME:** _____

I believe this child is able to attend a summer group program and participate in its activities. I give my permission for the camp nurse to administer the above-listed medications.

_____ _____

Name of Physician (print or stamp) Date of Examination

_____

Physician's address and phone number

_____ _____

Signature of PHYSICIAN Signature of PARENT