

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: _____ |

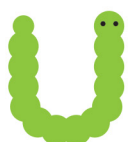
Describe abnormal findings and/or handicapping conditions:

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.



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