USDAN SUMMER CAMP FOR THE ARTS

PROUD PARTNER UJA Federation NEW YORK

HEALTH FORM

Due May 31, 2025

Email to: healthoffice@usdan.org or **Mail to**: 185 Colonial Springs Road, Wheatley Heights, NY 11798

Child's Last Name _____ Child's First Name _____

PHYSICAL EXAMINATION

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: _____

Please note information on reverse side.

IMMUNIZATIONS

(Required – You may attach a separate sheet)

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

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

*Please complete the additional forms "Parent and Physician's Authorization for Administration of Medication at Usdan" and "Emergency Self Medication Release Form" if applicable

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