PIERCE COUNTRY DAY SCHOOL/CAMP INC.

2012 HEALTH FORM

Mineola Avenue, Roslyn, NY 11576 (516) 621-2211 Fax (516) 621-5765

Child's Name: ________________________________ Date of Birth: ____/____/____

Address: ________________________________ Home Phone: ( )____________

Father's Name: ________________________________ Cell Phone: ( )____________

Business Phone: ( ) __________ **Father's Email** ______________________________

Address (if different from above): ______________________________

Mother's Name: ________________________________ Cell Phone: ( ) ____________

Business Phone: ( ) __________ **Mother's Email** ______________________________

Address (if different from above): ______________________________

Emergency Name (Friend): ______________________________ Phone: ( ) ____________

Emergency Name (Relative): ______________________________ Phone: ( ) ____________

Name & Phone of country club or recreation area where you can be reached between 9am and 4:00pm:

______________________________ Phone: ( ) ____________

Permission to send home to housekeeper: ☐ Yes ☐ No Name: ______________________________

Permission to give Tylenol for fever or pain: ☐ Yes ☐ No

Health Problems: 1.______________ 2. ______________ 3. ______________

Allergies: __________ If Yes, specify: ______________________________

Parents Signature: ______________________________

IMPORTANT – This Box MUST Be Completed For Attendance Please sign below

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the Director to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director to secure and administer treatment, including hospitalization for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian: ______________________________ *Date:* ______________

Please Print Name: ______________________________ *Relation:* ______________

Medical Authorization

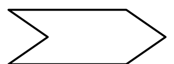
I ______________________, parent or guardian of ______________________,
authorize any physician, nurse or other health care provider to communicate with the medical staff and director of the camp, or his/her designee, about my child's medical condition, and or prognosis.
We further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or this child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.
These authorizations are limited to June 28, 2012 through August 22, 2012

Signature of Parent or Guardian: ______________________________ Date: ______________

*If for religious reasons, you cannot sign this, then the camp should be contacted for a legal waiver that MUST be signed for attendance.

THIS SIDE OF THE FORM TO BE COMPLETED BY PARENT OR GUARDIAN

TURN OVER



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2012 HEALTH FORM

Camper's Name: ____________________

Height: __________ Weight: __________ Blood Pressure: __________ Pulse: __________

Vision: RIGHT /20 LEFT /20 Glasses: __________

Contact Lens: __________

Exam	Normal	Abnormal	Description
Eyes			
Ears			
Nose & Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitals			
Skin			
Extremities			
Spine			
Neurological			
Other			

Medications: ____________________

Previous Illness: ____________________

Has Child Had Chicken Pox: ☐ Yes ☐ No Vaccinated: ____________________

Operations: ____________________

Immunizations: Must include DPT or DT & 3 OPV; Measles; Mumps; Rubella

DPT: 1. ____/____/___ 2. ____/____/___ 3. ____/____/___ 4. ___/____/___

OPV: 1. ____/____/___ 2. ____/____/___ 3. ____/____/___ 4. ___/____/___ Lead Levels________

Measles: 1. ____/____/____ 2. ____/____/____ Mumps: ______________ Rubella: ___________

HIB: __________/__________/__________ TB: __________/__________/__________

Hepatitis B: __________/__________/__________ Other: ____________________

Recommendations: ____________________

In my opinion, the above child ☐ may ☐ may not participate in all activities.

Limitations: ____________________

Physician's Signature: ____________________ Physician Stamp: __________

Address: ____________________

Phone: ( ) ____________________ ****Date of Exam:** ____________________ **

THIS SIDE OF THE FORM TO BE COMPLETED BY PHYSICIAN