FORM A

Museum of Long Island

Health History Form - Summer Camp 2023

(This form should be filled 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: _____

In case of emergency, notify: _____ Phone: _____

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 _____

❑ Chicken Pox _____

❑

❑

❑

Allergies

❑ Hay Fever _____

❑ 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.#_____

FORM B

PHYSICAL EXAMINATION

(To be filled out by Physician – please note: a school physical form may be submitted in lieu of this form)

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, After-School 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					
MMR					
Hemophilus Influenzae type b (Hib)				Date _____	Date _____
Hepatitis B	Date _____				
Varicella					
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____		Other _____		Other _____	

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 _____

Eyes _____Vision _____w/Glasses _____ Extremities _____ Heart _____

Neurological Findings _____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp:

Special Diet _____

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