the center
Morris & Paulette Bailey
Sephardic Community Center
1901 Ocean Parkway
Brooklyn, NY 11223

2020-Day Camp Health Form

To be completed by camper parent

FOR OFFICE USE ONLY: Received By _____ Date_____

Camper ID: _____ Grade:_____ Unit: _____ Group: _____

Camper Name: _____ Birthdate: _____ Gender: ____ Age: ____

Parent or Guardian: _____

Home Address:_____ Phone:_____

Business Second Parent or Guardian:_____

Home Address: _____ Phone: _____

Mother's Cell:_____ Father's Cell: _____

Business: _____ Phone:_____

If not available in the case of an emergency, notify (please list 3 options)

Name _____ Relationship _____ Phone 1_____ Phone 2 _____

Name _____ Relationship _____ Phone 1_____ Phone 2 _____

Name _____ Relationship _____ Phone 1_____ Phone 2 _____

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions _____

Current Medications (send with instructions) _____

Other diseases _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate: Carrier _____ Policy/Group # _____

Suggestions on health related information for camp personnel _____

Health History

(Check. Give approximate dates.)

☐ _____ Frequent Ear Infections
☐ _____ Heart Defect/Disease
☐ _____ Convulsions
☐ _____ Diabetes
☐ _____ Bleeding/Clotting Disorders
☐ _____ Hypertension
☐ _____ Mononucleosis

Diseases

☐ _____ Chicken Pox
☐ _____ Measles
☐ _____ German Measles
☐ _____ Mumps

Allergies (Dates not needed)

☐ _____ Hay Fever
☐ _____ Ivy Poisoning, etc.
☐ _____ Insect Stings
☐ _____ Penicillin
☐ _____ Other Drugs
☐ _____ Asthma
☐ _____ Other *(Specify)*

FOR FEMALES: Menstruated ☐ Yes ☐ No Normal ☐ Other ☐

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2020-Day Camp Health Form

To be completed by Health Professional

BY DOCTOR

COVID-19 Test Required

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B __/__/__ __/__/__ __/__/__ __/__/__

Rotavirus __/__/__ __/__/__ __/__/__

DTP/DTaP/DT __/__/__ __/__/__ __/__/__ __/__/__

__/__/__ __/__/__ __/__/__ __/__/__

Hib __/__/__ __/__/__ __/__/__ __/__/__

PCV __/__/__ __/__/__ __/__/__ __/__/__

Polio __/__/__ __/__/__ __/__/__ __/__/__

Influenza __/__/__ __/__/__ __/__/__

MMR __/__/__ __/__/__ __/__/__

Varicella __/__/__ __/__/__

Td __/__/__ __/__/__ __/__/__

Tdap __/__/__ Hep A __/__/__ __/__/__

Meningococcal __/__/__ __/__/__

HPV __/__/__ __/__/__ __/__/__

Other, *Specify:* _____ __/__/__; _____ __/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __/__/__

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

DOHMH ONLY PROVIDER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ I.D. NUMBER

REVIEWER:

CH-205 (5/08)

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian