the center
MORRIS & PAULETTE BAILEY
SEPHARDIC COMMUNITY CENTER
1901 OCEAN PARKWAY
BROOKLYN, NY 11223

2026 DAY CAMP HEALTH FORM

the center DAY CAMP

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.)

		Diseases		*Allergies (Dates not needed)*	
☐ _____	Frequent Ear Infections	☐ _____	Chicken Pox	☐ _____	Hay Fever
☐ _____	Heart Defect/Disease	☐ _____	Measles	☐ _____	Ivy Poisoning, etc.
☐ _____	Convulsions	☐ _____	German Measles	☐ _____	Insect Stings
☐ _____	Diabetes	☐ _____	Mumps	☐ _____	Penicillin
☐ _____	Bleeding/Clotting Disorders			☐ _____	Other Drugs
☐ _____	Hypertension			☐ _____	Asthma
☐ _____	Mononucleosis			☐ _____	Other *(Specify)*

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

2026 DAY CAMP HEALTH FORM
TO BE COMPLETED BY DOCTOR

the center
MORRIS & PAULETTE BAILEY
SEPHARDIC COMMUNITY CENTER
1901 OCEAN PARKWAY
BROOKLYN, NY 11223

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

Medications *(attach MAF if in-school medication needed)*
☐ None   ☐ Yes *(list below)*
_____
_____

Dietary Restrictions
☐ None   ☐ Yes *(list below)*

Explain all checked items above or on addendum

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:

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

	Date Done	Results
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)*	__ / __ / __	☐ Nl ☐ Not ☐ Abnl 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 __ / __ / __

DOHMH ONLY	**PROVIDER I.D.** [ ][ ][ ][ ][ ][ ][ ]

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

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

Facility Name _____   National Provider Identifier (NPI) _____

Comments

Address _____   City _____   State ___ Zip _____

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

Telephone (___ ___ ___) _____   Fax (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

REVIEWER: _____