OLD WESTBURY Summer Camp
25 Store Hill Road, Old Westbury, N.Y. 11568
Phone (516) 626-9268/Fax (516) 626-7914

Dear Parent/Guardian:

In compliance with the Nassau County Department of Health, a current medical and record of your child's immunizations must be on file in the camps nurse's office by their first day of camp. Parent/Guardian must complete first page of the form, sign and date. The physician must complete page 2 and fill out the required information on the bottom. Return the form to the camp prior to your child's start date. Thank you.

Camper: _____ Date of Birth: _____
Address: _____ Home Telephone: _____
_____
Mother/Female Guardian: _____ Father/Male Guardian: _____
Mother's Cell Phone #: _____ Father's Cell Phone #: _____
Work Address: _____ Work Address: _____
_____ _____
Work Phone #: _____ Work Phone #: _____

Emergency Contacts: ***(This information must be provided)***
Name of Contact #1: _____ Name of Contact #2: _____
Address: _____ Address: _____
_____ _____
Telephone #: _____ Telephone #: _____

HISTORY

	DATE		DATE		CHECK
Anemia		Sickle Cell		Asthma	
Chicken Pox		Heart Disease		Allergy	
Diabetes		Pneumonia		Surgeries	
Seizure		Tuberculosis		Serious Injuries	

ANY SERIOUS ILLNESS OTHER THAN ABOVE □ DETAILS IF PERTINENT _____
_____
Is your child supposed to wear glasses □ YES □ NO Does your child wear contact lens? □ YES □ NO

Please list any allergies your child has: _____

Please list any special medication your child is taking: _____
An "Authorization to Administer Medication" form must be completed by your child's physician if medication is required to be administered during the camp day by the nurse.

Does your child have any physical or emotional condition(s) requiring restriction of his/her participation in physical activity? ____YES ____NO If YES, please contact the camp nurse to discuss.

Parent/Guardian Signature: _____ Date: _____

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Camp Health Form / Physician's Certificate

THIS FORM MUST BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR

Camper's Name: _____ DOB: _____

Height: _____ Weight: _____

Body Mass Index: _____ _____ _____

Weight Status Category (BMI Percentile):

□ Less than 5th □ 5th through 49th □ 50th through 84th

			Referral
Vision – without glasses/contact lenses	R	L	
Vision – with glasses/contact lenses	R	L	
Vision – Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

Blood Pressure: _____
Nutrition: _____
Teeth and Gums: _____
Glands – Cervical: _____
Heart and Lungs: _____
Orthopedics: Spinal deviation: _____
Genitalia (male):

Nervous System: _____
Speech: _____
Tonsils and Throat: _____
Thyroid: _____
Skin: _____
Scoliosis: _____ Feet: _____
Urinalysis (if done):

Does this child have any condition requiring on-going medical care? ____YES ____NO

If YES, please specify: _____

Are there any issues relating to growth, development or nutrition with which his/her teachers should be acquainted?

____YES ____NO

If YES, please specify: _____

Should any restrictions be placed on this child's participation in physical activities? ____YES ____NO

If YES, please specify: _____

Does this child take any medication (other than vitamins) on a regular basis? ____YES ____NO

If YES, please specify: _____

Are there any other medical issues of which the school should be aware regarding this child? ____YES ____NO

If YES, please specify: _____

Immunizations:	Date(s) of Administration(s):
1. Polio/OPV	1____ 2_____ 3 _____
	Booster ____ _____
2. DPT/DTAP	1____ 2_____ 3 ____
	Booster_____ _____
Tdap	_____
3. TD	1____ 2____ 3 _____
4. HbCV /Hib	1 ____ 2 ____
5. Varicella	1 ____ 2 ____
6. PCV (Prevnar)	1 ____ ____ ____ ____
7. Menactra	1 ____
8. M/M/R	1 ____ 2* ____
OR	
Measles	1 ____ 2* ____
Mumps	1 ____
Rubella	1 ____
9. Hepatitis B	1 _____ 2 _____ 3 _____
10. Mantoux (within 1 Year)	1 _____ (Required for new entrants including the results)

** Necessary for children born on or after January 1, 1985*

Physician's Name: _____ License #: _____

Address: _____

Telephone #: _____ Date of Examination: _____