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

2025 DAY CAMP HEALTH FORM

the center DAY CAMP

To be completed by <u>camper parent</u>

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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TO BE COMPLETED BY DOCTOR

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:

	Nl	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)*	__/__/__	☐ Nl ☐ 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	Influenza	
Rotavirus	MMR	
DTP/DTaP/DT	Varicella	
	Td	
Hib	Tdap / Hep A	
PCV	Meningococcal	
Polio	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)
Comments

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

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

Telephone (___ ___) ___ ___ ___ – ___ ___ ___ ___ | Fax (___ ___) ___ ___ ___ – ___ ___ ___ ___

REVIEWER:

CII-205 (5/08)

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