2014 HEALTH FORM

CHILD'S LAST NAME:	CHILD'S FIRST NAME	PARENT/GUARDIAN:
DATE OF BIRTH	HOME PHONE:	ADDRESS:
RETURN FORM TO: Elbow Lane Day Camp 828 Elbow Lane, Warrington, PA 18976 Phone (215)343-2120 Fax (215)933-1469		WORK/CELL PHONE:

I give my consent for my child's Physician and Camp Nurse to discuss my child's health concerns.

________________________________ ________________

PARENT/GUARDIAN SIGNATURE DATE

ANY HEALTH HISTORY AND/OR MEDICAL INFORMATION PERTINENT TO ROUTINE CAMP ACTIVITIES OR EMERGENCIES: ☐ **NO** ☐ **YES (IF YES, PLEASE SPECIFY)**

CHILD MAY PARTICIPATE IN ALL ACTIVITIES: ☐ **YES** ☐ **NO (IF NO, PLEASE SPECIFY)**

ALLERGIES TO FOOD OR MEDICINE: ☐ **NO** ☐ **YES (IF YES, PLEASE SPECIFY)**

HEIGHT	**WEIGHT**	**PULSE**	**BLOOD PRESSURE**
___________INCHES	_________LBS	_______________	_____________/______________

PHYSICAL EXAMINATION	**NORMAL**	**ABNORMAL/COMMENTS**
HEAD/EARS/EYE/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINT/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (E.G. DDST)		

IMMUNIZATIONS	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**COMMENTS**
DTP/DTaP	1	2	3	4	5	
POLIO	1	2	3	4		
HIB	1	2	3	4		
HEP B	1	2	3			
MMR	1	2				
VARICELLA	1	2				
MENINGOCOCCAL	1					
LAST TETANUS	1					

NOTE: Ages and number of boosters may vary when immunizations start at older ages.

PLEASE CONTINUE ON OTHER SIDE

HAS THIS CHILD EVER HAD ANY SERIOUS ILLNESS, INJURY, OPERATION OR HOSPITALIZATION? ☐ NO ☐ YES, SPECIFY.

IS THIS CHILD CURRENTLY TAKING ANY MEDICINES? ☐ NO ☐ YES, SPECIFY.

IS THIS CHILD TO RECEIVE ANY PRESCRIPTION MEDICINE AT CAMP? ☐ YES ☐ NO

IF YES: ______________________________ __________________ ______________________
MEDICINE DOSE TIME

______________________________ __________________ ______________________
MEDICINE DOSE TIME

NOTE: Medication will not be administered to any child without the proper completion of the Medication Dispensing Form. This form can be printed from our website (www.elbowlane.com) under "Camp Forms", or call the office to request a copy.

DATE OF LAST DENTIST'S EXAMINATION __________________

NOTE: Age appropriate health services and immunizations must follow the Schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007

HEALTH PROBLEMS OR SPECIAL NEEDS	**RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE:** (ATTACH ADDITIONAL SHEETS IF NECESSARY)
NO PROBLEMS ☐	

MEDICAL CARE PROVIDER:

ADDRESS:

PHONE:

_________ ____
DATE SIGNATURE OF PARENT OR GUARDIAN

OPTIONAL:

____________ ________________________________
DATE SIGNATURE OF PHYSICIAN OR CRNP