

## HEALTH FORM

Due May 31, 2023

**Email to:** healthoffice@usdan.org or **Mail to:** 185 Colonial Springs Road, Wheatley Heights, NY 11798

Child's Last Name \_\_\_\_\_ Child's First Name \_\_\_\_\_

### PHYSICAL EXAMINATION

General appearance: \_\_\_\_\_

Height: \_\_\_\_\_ Eyes: \_\_\_\_\_ Nose: \_\_\_\_\_

Weight: \_\_\_\_\_ Vision: \_\_\_\_\_ Throat-tonsils: \_\_\_\_\_

Posture & Spine: \_\_\_\_\_ Glasses/Contacts: \_\_\_\_\_ Abdomen: \_\_\_\_\_

Feet: \_\_\_\_\_ Ears: \_\_\_\_\_ Hernia: \_\_\_\_\_

Skin: \_\_\_\_\_ Hearing: \_\_\_\_\_ Genitalia: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Teeth: \_\_\_\_\_ Neurological Findings: \_\_\_\_\_

Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_ Other: \_\_\_\_\_

Describe abnormal findings and/or handicapping conditions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List allergies or current medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any restriction as to: Swimming: \_\_\_\_\_ Diving: \_\_\_\_\_

Other: \_\_\_\_\_

Please note information on reverse side.



## IMMUNIZATIONS

(Required - You may attach a separate sheet)

Immunization Records	Dates				
DPT					
Polio					
Measles/Mumps/Rubella					
Hepatitis B					
Varivax					
Haemophilus B (HIB)					
Meningitis					
Other:					

## MEDICATIONS

For pain &/or fever > 100°F: CHILDREN'S MOTRIN: \_\_\_mg q6h OR CHILDREN'S TYLENOL: \_\_\_mg q4h

For hives/allergic reactions:

CHILDREN'S BENADRYL-q6h: \_\_\_12.5mg \_\_\_18.75mg \_\_\_25mg \_\_\_31.25mg \_\_\_37.5mg \_\_\_43.75mg \_\_\_50mg

### PRESCRIPTION MEDICATIONS TO BE TAKEN DURING CAMP

\*Please complete the additional forms "Parent and Physician's Authorization for Administration of Medication at Usdan" and "Emergency Self Medication Release Form" if applicable

NAME: \_\_\_\_\_ DOSAGE/TIME: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE/TIME: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE/TIME: \_\_\_\_\_

I believe this child is able to attend a summer group program and participate in its activities. I give my permission for the camp nurse to administer the above-listed medications.

\_\_\_\_\_  
 Name of Physician (print or stamp)

\_\_\_\_\_  
 Date of Examination

\_\_\_\_\_  
 Physician's address and phone number

\_\_\_\_\_  
 Signature of PHYSICIAN

\_\_\_\_\_  
 Signature of PARENT