HURLEY RECREATION REC RATS HEALTH RECORD

(This side is to be completed by Parent before presenting to Physician)

______________________ ______________________ ____/____/____ ○ FEMALE ○ MALE

CHILD'S LAST NAME CHILD'S FIRST NAME DATE OF BIRTH

HOME ADDRESS CITY/STATE/ZIP CODE HOME TELEPHONE NUMBER

PARENT'S OR GUARDIAN'S NAME CONTACT TELEPHONE

FATHER'S PLACE OF EMPLOYMENT TELEPHONE

MOTHER'S PLACE OF EMPLOYMENT TELEPHONE

IN CASE OF EMERGENCY-NOTIFY TELEPHONE

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY, NOTIFY: (FAMILY PHYSICIAN)

1.______________________ ______________

OR TELEPHONE

2.______________________ ______________

TELEPHONE

IMPORTANT: Please notify Hurley Rec personnel if Child was/is exposed to any communicable disease at anytime three weeks prior to Rec Rats attendance.

○NO ○YES If YES, please give type of exposure:

____

HEALTH HISTORY (Check, giving approximate dates):

Asthma:__________ Behavior:__________ Chicken Pox:__________

Convulsion:__________ Diabetic:__________ Ear Infection:__________

Hay Fever: __________ Insect Stings: __________ Ivy Poisoning, etc: __________

Measles: __________ German Measles: __________ Mumps: __________

Past Illness: __________ Contagious illness: __________

Other Drugs: __________ Penicillin: __________ Rheumatic Fever: __________

Operations or Serious Injuries (Dates): __________

Hospitalization: __________

Chronic or Recurring Illness: __________

Other Diseases or details of above: __________

Any specific activities to be encouraged? __________

Any specific activities to be restricted? __________

Permission for all program activities unless otherwise noted by physician:

____

Suggestion from Parent(s) or Guardian:______________________

SIGNIFICANT HEALTH HISTORY AND CURRENT CONDITIONS

PLEASE LIST:
Medication taken: ____________________
Appliance worn (Glasses, Hearing Aid, etc.): ____________________
Conditions that modify activity (seizures, asthma, heart condition, etc.): ____________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby give my consent/authority to the Staff of the Hurley Recreation Rec Rats program to obtain the necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.
Relationship: ____________ Signature: ____________ Telephone: ____________ Date: ________

(To be filled out by Physician – Please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the need of the aforementioned Child in the Hurley Recreation Rec Rats program.

IMMUNIZATION HISTORY *(This is a record of dates of basic immunization and most recent booster doses)*

DPT or DT or TD – DATE:________ DATE:________ DATE: ________ DATE:________ DATE:________
POLIO - DATE:________ DATE:________ DATE:________ DATE:________ DATE:________
MEASLES- DATE:________
MUMPS- DATE:________
RUBELLA- DATE:________

(PPD-MANTOUX)

Tuberculin Test given: ______________ (most recent) Result:________ ☐ ☐ m m

MEDICAL EXAMNATION *(To be completed by licensed Physician)*

EXAMINATION IS ACCEPTABLE WHEN PERFORMED NO MORE THAN 12 MONTHS PRIOR TO ARRIVAL AT CAMP.
CODE: **S** = SATISFACTORY **X** = NOT SATISFACTORY (EXPLAIN) **O** = NOT EXAMINED

GENERAL APPEARANCE ____________________

HEIGHT ________ WEIGHT ________ BLOOD PRESSURE ________ HGB. TEST ________

URINALYSIS ________ POSTURE & SPINE ________ THROAT/TONSILS ________

EYES ________ VISION ________ GLASSES ________ EXTREMETIES ________

HEART ________ EARS ________ HEARING ________ FEET ________

LUNGS ________ SKIN ________ NOSE ________ TEETH ________

ABDOMEN ________ HERNIA ________ GENITALIA ________

ALLERGY (PLEASE SPECIFY):____________________

EUROLOGICAL FINDINGS:____________________

DESCRIBE ABNORMAL FINDINGS AND/OR HANDICAPPING CONDITIONS:____________________
____

SPECIAL DIET

MEDICAL MEDICATION (GIVE NAME AND DOSAGE)

PARENT/GUARDIAN SEEKING SPECIAL MEDIATION?

SWIMMING STRENUOUS ACTIVITY

GENERAL APPRAISAL:

I HAVE EXAMINED THE INDIVIDUAL HEREIN DESCRIBED, REVIEWED HIS/HER HEALTH HISTORY AND IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP/YEAR ROUND AFTERSCHOOL AND YOUTH CENTER ACTIVITIES, EXCEPT AS NOTED ABOVE.

M.D.

PHYSICIAN'S SIGNATURE DATE

ADDRESS CITY/STATE ZIP CODE