EHSC @ SPORTIME AMAGANSETT
PHYSICAL EXAMINATION
AND IMMUNIZATION RECORD

P O Box 778, Amagansett NY 11930
tel: 631/267-CAMP fax: 631/267-1082

(to be completed by physician)

Dear Parent or Guardian:
The Suffolk County Dept. of Health requires that we have the information below on file for each EHSC @ SPORTIME AMAGANSETT camper. Kindly forward this form to your child's physician and have him/her complete and return the form to us at the address below as quickly as possible. Your doctor may choose to substitute his/her own appropriate form, but no camper can be allowed to participate in summer camp without having supplied these records. Thank you for your cooperation.

Camper's Full Name_____ Birth date_____

Address_____

Height: Feet/Inches_____ Weight_____ Posture_____

Condition Of: Skin_____ Ears_____ Nose_____

Throat_____ Tonsils_____ Thyroid_____

Heart_____ Pulse_____ BP_____

Teeth_____ Eyes: Right_____ Left_____ Glasses_____

Nervous System_____

Laboratory: Hemoglobin_____

Urinalysis: Albumin_____ Sugar_____

ALLERGIC CONDITIONS: Hay Fever_____ Asthma_____

Drug Allergies_____

Food Allergies_____

Immunizations: (Please give dates)

DPT	1._____	2._____	3._____	4._____	5._____
Sabin Polio	1._____	2._____	3._____	4._____	
Measles	1._____	2._____			
Mumps	1._____				
Rubella	1._____				
MMR	1._____	2._____			
HIB	1._____				

Haemophilus Influenza Type B _____ Hepatitus B _____ Varicella (chicken pox) _____

Tuberculin Test: (within last 12 months) Date_____ Results_____

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Camper's Name _____

Does the camper have any temporary or permanent physical, emotional or health problem about which the camp should be informed?

_____

_____

_____

_____

Is the camper currently under any medical treatment? _____ If yes, please specify:

_____

_____

_____

Is the camper currently on medication? _____ If yes, please specify:

_____

_____

Please list any other information you may have that may be of use to the camp:

_____

_____

Physician's Signature _____ M.D.

Address: _____

_____

Telephone: _____