

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 _____ Hepatitis 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: _____