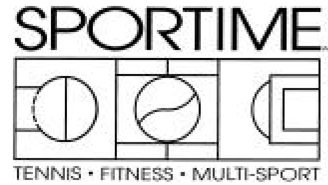
SPORTIME
PHYSICAL EXAMINATION
AND IMMUNIZATION RECORD
(to be completed by physician)



Dear Parent or Guardian:
The Suffolk County Dept. of Health requires that we have the information below on file for each SPORTIME 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 SPORTIME summer camp without having supplied these records. Thank you for your cooperation.

Camper's Full Name____ Birthdate_________________

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_____________________

Camper's Name ____

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

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

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

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

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Physician's Signature ____ M.D.

Address: ____

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Telephone: ____