Sandy Hollow Day Camp

P.O. BOX 1402 • SOUTHAMPTON, NY 11969
(631) 283-2296 • WWW.SANDYHOLLOWDAYCAMP.COM

TO BE COMPLETED BY PARENT

Health Form

Child's Name _____ Sex _____ Birthdate _____

Name of parent/guardian _____

Address _____

_____ Home Phone _____

Cell Phone _____ Email Address _____

Name of person to notify if parent/guardian cannot be reached

_____

Relationship _____

Address _____

_____ Phone _____

Family physician _____

Address _____

_____ Phone _____

Insurance company _____ Policy/cert. No. _____

Comments:

Signature _____

TO BE COMPLETED BY PHYSICIAN

MEDICAL HISTORY

Is the child in good health? _____

If not, give details: _____

_____

Should nature and amount of physical exercise be limited? Yes _____ No _____

If yes, explain: _____

Medicines to which child is sensitive or allergic? _____

_____

Medicines child is taking regularly or needs to have on hand _____

_____

List hospital admissions, operations, and significant injuries, with dates. _____

_____

Tetanus toxoid: Date of last booster _____

MEDICAL HISTORY

SHOTS	DATE	SHOTS	DATE
DPTS	_____	Rubella	_____
(3 doses)	_____	Mumps	_____
	_____		
Polio	_____	Tine Test for TB	_____
Oral Drops	_____		
(Sabin)	_____	Other _____	
HIB 1 dose 15 mos.	_____	_____	
1 Skin test	_____	_____	
Haemophilus Influenza Type B	_____		
Hepatitis B	_____	Hives, hay fever, allergies	_____
Varicella Chicken Pox	_____	Eye, ear, or throat	_____
Rheumatic fever	_____	High or low blood pressure	_____
Tuberculosis	_____	Bone or joint disease	_____
Asthma	_____	Liver disease, hepatitis	_____
Diabetes	_____	Stomach or bowel trouble	_____
Thyroid Disease	_____	Kidney or urinary problems	_____
Emotional Difficulties	_____	Epilepsy, convulsions	_____
Pneumonia, pleurisy	_____	Measles	_____
Heart disease, murmurs	_____		

Does child have a physical handicap? If so, explain: _____

_____

_____

_____

Is there anything else we should know? _____

_____

_____

_____

Doctor's Signature _____ Date _____