

Calvary Tabernacle Summer Camp

80 N. Franklin St, 2nd Fl. Hempstead, NY 11550. (516) 292-3685, Fax (516) 292-2821

HEALTH EVALUATION

Date of Exam: _____

Child's Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ BP: _____

Hearing Test Result: _____ Tested with Hearing Aid: Yes ___ No ___

Vision Test Result: _____ Tested with Glasses: Yes ___ No ___

Physician's assessment of dental status _____

IMMUNIZATIONS (Give Dates)

DTP/DTAP _____

OPV/DTAP _____

HIB _____

Pneumovax (mandatory for children with severe asthma, sickle cell, HIV, or kidney disease) _____

MMR _____

VARICELLA _____

PAST ILLNESSES (Give Dates)

Frequent Colds _____ Chicken Pox _____ Mumps _____ Measles _____

Rheumatic Fever _____ Diabetes _____ Hay Fever _____ Asthma _____

Epilepsy _____ Last Tuberculin Test: Date Implanted _____ Date Read _____

Results _____ (mm)

Medical Allergies _____ Food Allergies _____

Lead Level _____

Describe any surgery or accident _____

In your opinion, is this child physically and emotionally able to participate in the activities of summer camp program?

Does this child have any physical conditions that would require special attention while at summer camp? If yes, please explain.

Have you prescribed any medication or special routine of which you feel the camp should be aware? If yes, please explain.

Physician's Name (print) _____ Signature _____
