KENWAL DAY CAMP
100 Drexel Ave
Melville, New York 11747
Tel 631.694.3399 Fax 631.694.3841

STAFF MEDICAL

TO BE FILLED OUT BY A LICENSED PHYSICIAN. This examination must be performed prior to the start of camp. Examination for some other purpose within the last year will be acceptable.

Name_____M_____ F_____ Home Phone_____Cell_____

Address_____

Hgt_____Wgt_____Extremities_____Eyes_____Ears_____Nose_____Throat_____

Teeth_____Heart_____Lungs_____Abdomen_____Hernia_____Posture (spine)_____Skin_____

ALLERGIES/specify_____

GENERAL APPRAISAL_____

ARE ALL IMMUNIZATIONS UP TO DATE?

DPT series_____Booster_____Tetanus Booster_____Typhoid_____Polio_____Booster_____

Tuberculin Test_____Measles Vaccine(Live)_____German Measles (Rubella)_____Mumps)Vaccine)_____

Haemophilus Influenza type b_____ Hepatitis b____Varicella(Chicken Pox) _____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND REVIEWED HIS/HER HEALTH HISTORY.

DATE_____EXAMINING PHYSICIAN_____

TELEPHONE_____ADDRESS_____

STAFF MEMBERS UNDER 18, PLEASE HAVE BOTTOM PORTION OF THIS APPLICATION COMPLETED BY PARENT OF GUARDIAN

I hereby give permission to the Camp Kenwal nurse to dispense any over the counter medicine to my child where she deems it necessary in the event that I cannot be reached.

YES_____NO_____PARENT/GUARDIAN SIGNATURE_____

AUTHORIZATION FOR TREATMENT

I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR TO ORDER X-RAYS, ROUTINE TESTS.TREATMENT AND NECESSARY TRANSPORTATION FOR ME/OR MY CHILD. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR MY CHILD AS NAMED ABOVE. THE COMPLETED FORMS MAY BE PHOTOCOPIES FOR TRIPS OUT OF CAMP.

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PARENT/GUARDIAN SIGNATURE **DATE**