

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 children's Tylenol 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.

PARENT/GUARDIAN SIGNATURE

DATE

