PARK SHORE COUNTRY DAY SCHOOL
HEALTH INFORMATION – SCHOOL 2020-2021

MUST BE COMPLETED & RECEIVED PRIOR TO CAMP BY PARENT OR GUARDIAN

The information on this form is to assist us in planning appropriate care. Updates should be provided to the office as they occur.

Child's Name ____
Last First Middle

Birth date ______________ Age at school _________ Present Grade (2020-2021) _____________ Gender _______

Home address ____ Primary phone _______________
Street address City Zip

Father's Name __________________________________ Home address _________________________________
(if different from above)

Business Phone ________________________________ Cell Phone _____________________________________

Mother's Name _________________________________ Home address _________________________________
(if different from above)

Business Phone ________________________________ Cell Phone _____________________________________

Emergency Contact (Other than parents) Relationship Home/Work/Cell Phone

____

____

Allergies (List all known) Describe reaction and management of the reaction.

Medication allergies (list)

_____________________________ ____

_____________________________ ____

Food allergies (list)

_____________________________ ____

_____________________________ ____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____________________________ ____

_____________________________ ____

Restrictions (The following restrictions apply to this individual.)

Food: Red meat __ Pork ___ Dairy Products ___ Poultry ___Fish/Seafood ___ Eggs __ Other (describe) ________

Activity Restrictions: (e.g. What accommodations or limitations are necessary?)

____

*IN THE EVENT THAT I OR MY CONTACTS CANNOT BE REACHED IN AN **EMERGENCY**, I HEREBY GIVE MY PERMISSION TO PARK SHORE, THE LOCAL AMBULANCE/FIRE DEPARTMENT, MY FAMILY PHYSICIAN, ANY LOCAL PHYSICIAN, OR THE NEAREST HOSPITAL TO ADMINISTER EMERGENCY TREATMENT AND CARE. I FURTHER GIVE MY PERMISSION FOR ALL PERTINENT HEALTH INFORMATION TO BE DUPLICATED AND RELEASED TO THE APPROPRIATE PERSONNEL FOR EMERGENCY CARE.*

____
Signature of Parent/Legal Guardian Date

In order to better accommodate your child's needs; does your child receive special services in school or anywhere else? _____ Yes _____ No

If yes, please explain. ____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

MEDICATIONS

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the child's name, the prescribing physician (if a prescription drug,) the name of the medication, the dosage, route, and the frequency of administration. Ensure that medications are not expired. *A **Medication Administration Form*** (this form can be downloaded from our website) *MUST accompany all medications to be administered, routine or on an 'as needed' basis.*

This person **takes NO medications** on a routine basis. OR ___ This person **takes medications** as follows:

Med #1 ____________________ Dosage __________ Specific times taken each day ________________________

Reason for taking ____

Med #2 ____________________ Dosage __________ Specific times taken each day ________________________

Reason for taking ____

GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the participant?	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?			15. Ever been diagnosed with a heart murmur?		
2. Have a chronic or recurring illness/condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints (e.g. knees, ankles)?		
4. Ever had surgery?			18. Have an orthodontic appliance being brought to camp?		
5. Have frequent headaches?			19. Have any skin problems (e.g. itching, rash, acne)?		
6. Ever had a head injury?			20. Have diabetes?		
7. Ever been knocked unconscious?			21. Have asthma?		
8. Wear glasses, contacts, or protective eyewear?			22. Had mononucleosis in the past 12 months?		
9. Ever had frequent ear infections?			23. Had problems with diarrhea/constipation?		
10. Ever passed out during or after exercise?			24. If female, have an abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			25. Have a history of bed-wetting?		
12. Ever had seizures?			26. Ever had an eating disorder?		
13. Ever had chest pain during or after exercise?			27. Ever had emotional difficulties for which professional help was sought?		
14. Ever had high blood pressure?			28. Have Additional Health Concerns?		

Please explain any "yes" answers, noting the number of the questions: ____

____

Name of familydentist/orthodontist____

Address ____ Phone ________________________________

SEE ATTACHED FOR ANNUAL MEDICAL FORMS – TO BE COMPLETED BY PHYSCIAN

The Department of Health regulations require a complete ANNUAL physical exam in order to attend & participate in camp.

Please have your physician complete the attached form: annual physical exam & Immunizations/vaccinations.

FOR HEALTH OFFICE USE ONLY

CHILD PROFILE: __________

CHILD ANNUAL PHYSICAL EXAM: __________

CHILD IMMUNIZATION/VACINATION RECORD: __________

FANE REPORT: __________

ENTER COMPUTER: __________

Child's Name: ___________________

Date of Birth: _________________

Park Shore Country Day School

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Dix Hills, NY 11746

631-499-8580

Email: sue@parkshoredaycamp.com

*****MUST BE COMPLETED BY PHYSICIAN ANNUALLY OR**
PROVIDE PHYSICIAN'S ANNUAL PHYSICAL EXAM & IMMUNIZATION HEALTH HISTORY FORM

Which of the following has the participant had?

____ Measles ____ Hepatitis A

____ Chicken Pox ____ Hepatitis B

____ German measles ____ Hepatitis C

____ Mumps ____ Other

TB Test: Date of last test _________

Results: ____ positive ____ negative

*Height _____________ *Weight ____________

*Blood Pressure __________*Pulse_________

Please give all dates of immunization for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP						
Tdap						
Tetanus						
Polio (OPV/IPV)						
MMR or Measles or Mumps or Rubella						
Haemophilus influenza B						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Pneumococcal vaccine						
Meningococcal vaccine						

***REQUIRED BY PHYSCIAN**

I have examined the above child and in my opinion, the above child's condition DOES_______ DOES NOT______ preclude his/her participation in an active camp program. (Include Physician or Health Care Provider's stamp)

____

Licensed Physician's Signature Print Name Date

Address ____ Phone __________________________________