YES WE CAN COMMUNITY CENTER HEALTH RECORD FOR CHILDREN IN DAY CAMP & AFTERSCHOOL & YOUTH CENTERS (This side to be filled in by parent/guardian.)

Name of Program: ______________________________

Child's Last Name: ____________________ Child's First Name: ____________________

Birthdate: ____/____/______ Sex: ☐ Male ☐ Female

Home Address:

Parent/Guardian: ____________________ Phone: (______)__________

Place of Employment: Parent/Guardian #1: ____________________ Work Phone: (______)__________

Parent/Guardian #2: ____________________ Work Phone: (______)__________

In case of emergency, notify: ____________________ Phone: (______)__________

If Parent, Guardian are not available in an emergency, notify: ____________________

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance? ☐ Yes ☐ No

If yes, state type of exposure: ____________________

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infection: __________ Hay Fever: __________ Measles: __________

Rheumatic Fever: __________ Ivy Poisoning, etc.: __________ German Measles: __________

Convulsion: __________ Insect Stings: __________ Mumps: __________

Diabetes: __________ Penicillin: __________ Other Contagious Illnesses: __________

Behavior: __________ Other Drugs: __________

Asthma: __________ Chicken Pox: __________

Other Past Illnesses: ____________________

Operations or Serious Injuries (Dates) Hospitalization (Dates): ____________________

Chronic or Recurring Illness: ____________________

Any specific activities to be encouraged? Conditions that require activity to be restricted?: ____________________

Permission for all program activities unless otherwise noted by doctor: ____________________

Appliance worn (glasses, contacts, etc.): ____________________

Medication taken: ____________________

Suggestion from Parent/Guardian: ____________________

*****CONSENT FOR EMERGENCY MEDICAL TREATMENT*****

I do hereby give authority to the Yes We Can Community Center staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature: ____________________ Relationship: ____________________

Date: ____________________ Phone: (______)____________________

Child's Last Name: ________________________ Child's First Name: ________________________

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on opposite page.)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the needs of this child in Yes We Can Community Center programs.

IMMUNIZATION HISTORY: This is a record of dates of basic immunization and most recent booster doses.

DTaP/Tdap/DTP/Td	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Polio	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
MMR	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Haemophilus influenzae type B (Hib)	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Hepatitis B	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Varicella	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Other:	Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Other: ________				Date: ________	Date: ________

MEDICAL EXAMINATION: To be filled out by licensed physician

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: **S** = Satisfactory **X** = Not Satisfactory (Explain) **O** = Not Examined

General Appearance:

Height: ________ Weight: ________ Blood Pressure: ________ Hgb. Test (Date): ________

Urinalysis (Date): ________ Posture & Spine: ________ Throat – Tonsils: ________

Eyes: ________ Vision: ________ w/Glasses: ________ Extremities: ________

Heart: ________ Ears: ________ Hearing: ________ Feet: ________

Lungs: ________ Skin: ________ Nose: ________ Teeth: ________

Abdomen: ________ Hernia: ________ Genitalia: ________

Neurological Findings: ________

Describe Abnormal Findings and/or Handicapping Conditions: ________

Has child ever received products containing horse serum?: ________

Allergy: (Please specify): ________

Recommendations and restrictions while in camp: ________

Special Diet: ________

Special Medicine (name it): ________

Is parent/guardian sending special medicine?: ________

Swimming: ________ Diving: ________

Activity Restrictions: ________ General Appraisal: ________

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

Examining Physician (Signature): ________ Date of Examination: ________

Physician's Name (Please Print): ________

Address: ________ Zip Code: ________ Phone: (______) ________