

## Westchester Summer Day Health Form

**Mail to: Westchester Summer Day 856 Orienta Avenue Mamaroneck, NY 10543**

**Due Date: May 21, 2010**

For Office Only \_\_\_\_\_

**COMPLETE THIS SECTION BEFORE SUBMITTING TO YOUR PHYSICIAN**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Tel (\_\_\_\_) \_\_\_\_\_ Work Tel (\_\_\_\_) \_\_\_\_\_ Cell phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Tel (\_\_\_\_) \_\_\_\_\_ Work Tel (\_\_\_\_) \_\_\_\_\_ Cell phone \_\_\_\_\_

**TO ALL PARENTS:** We must receive a completed medical background on your child. If it is ever necessary to provide an immediate medical history to an EMT your thoroughness will assist in the comfort and safety of your child. **If you would like our nurse to administer medication to your child, you and your pediatrician must complete the enclosed Administration of Medication Release Form.**

**THIS SECTION TO BE COMPLETED BY A LICENSED PHYSICIAN - PLEASE COMPLETE ALL AREAS**

**Date of Exam:** \_\_\_\_\_ 2010

**Allergies:**  None  Yes detail: \_\_\_\_\_

<p><b>Current Medications</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p><b>Significant Medical History</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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**Physical Exam: Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **B/P** \_\_\_\_\_ **U/A** \_\_\_\_\_

**Vision** \_\_\_\_\_ **Hearing** \_\_\_\_\_ **Hgb** \_\_\_\_\_

- Normal
- Significant Findings \_\_\_\_\_

Immun.	Date	Date	Date	Date	Date
Hepatitis B					
DTaP (DTP)					
Hib					
OPV / IPV					
MMR					
Varivax					
PPD					
dT					
other					

I believe that this child should be restricted in activities in the following areas and/or ways:

I believe this child CAN participate in all activities. **Physician's Signature:** \_\_\_\_\_

Examining Physician \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. # \_\_\_\_\_