

Caravel Day Camp: 2010 Health Record

PART A: To be filled in by parent before physical examination

NAME: _____ SEX: _____ BIRTHDATE: _____
 ADDRESS: _____
 PHONE NUMBER: 1st: _____ 2nd: _____ 3rd: _____

Illness and Health Problems: Check and give additional information if necessary.

| | | |
|-----------------------|----------------------------|-----------------------------|
| Chicken Pox _____ | Frequent Colds _____ | Diabetes _____ |
| Measles _____ | Frequent Tonsillitis _____ | Convulsive Disorders _____ |
| Rubella _____ | Hearing Difficulty _____ | Heart Trouble _____ |
| Mumps _____ | Speech Difficulty _____ | Orthopedic Difficulty _____ |
| Whooping Cough _____ | Vision Difficulty _____ | Nephritis _____ |
| Rheumatic Fever _____ | Allergies _____ | Menstrual Difficulty _____ |
| Tuberculosis _____ | Asthma _____ | Other _____ |

Additional Information about your child (Include accidents, operations, etc.) Use back.

Immunization Dates: Please write in month, day, and year

| | | | |
|----------|----------|---------------|------------|
| DPT | Polio | Measles | Hepatitis: |
| #1 _____ | #1 _____ | _____ | #1 _____ |
| #2 _____ | #2 _____ | Mumps _____ | #2 _____ |
| #3 _____ | #3 _____ | Rubella _____ | #3 _____ |
| #4 _____ | #4 _____ | HIB _____ | |
| #5 _____ | #5 _____ | | |

PART B: To be completed by examining physician. Please indicate condition by code and give details under positive findings

Height: _____ Codes: No defect _____ Defect-correction or care not necessary _____
 Weight: _____ Defect-care or correction necessary _____

General Appearance

| | | | |
|------------------|---------------|--------------------|----------------------|
| Scalp-Skin _____ | Teeth _____ | Lungs _____ | Blood Pressure _____ |
| Eyes _____ | Neck _____ | Abdomen _____ | Urinalysis _____ |
| Ears _____ | Posture _____ | Hernia _____ | Other _____ |
| Nose _____ | Glands _____ | Extremities _____ | |
| Throat _____ | Heart _____ | Neurological _____ | |

Positive Findings: Include any pertinent history. Use back if necessary.

Recommendations: List any limitations. Use back if necessary.

Immunization given at this visit: _____
 Tuberculin Skin Test (PPD) Type: PPD Date: _____ Results: _____
 Physician's Signature: _____ Date: _____
 Address: _____ Phone: _____

Allergies
Epi-pen