



Dear Ivy League Parents,

Enclosed you will find our health survey for the upcoming summer. We realize it often takes time to schedule an appointment with your family physician; therefore we distribute this survey well before the beginning of summer.

We urge you to schedule an appointment with your child's physician as soon as possible and the forms are due in camp no later than **June 18th**. Each and every camper that attends Ivy League must have this form completed and handed in for them to attend camp.

Please note that the front of the survey is to be completed by you the parent and the back of the survey is to be completed by your physician.

Thank you for your prompt attention. We look forward to a summer of healthy fun.

See you in June,

Noah, Margaret, Linda & Nancy

IVY LEAGUE DAY CAMP

HEALTH SURVEY

IVY LEAGUE DAY CAMP
211 BROOKSITE DRIVE
SMITHTOWN, NY 11787
PHONE: (631) 265-4177
FAX: (631) 265-4698



Personal Information (TO BE COMPLETED BY A PARENT)

CAMPER'S NAME		
MOTHER'S NAME	MOTHER'S BUSINESS PHONE	
FATHER'S NAME	FATHER'S BUSINESS PHONE	
HOME PHONE	MOTHER'S CELL OR BEEPER	FATHER'S CELL OR BEEPER
FAMILY PHYSICIAN	PHYSICIAN PHONE	PHYSICIAN FAX
THERAPIST'S NAME	THERAPIST PHONE	THERAPIST PHONE

IN CASE OF EMERGENCY

If we cannot be reached, please contact:

NAME	RELATIONSHIP	PHONE

Please read the following and check all that apply:

- In the event that my family physician or I cannot be contacted in an emergency, I hereby grant permission to bring my child to a hospital emergency room.
- In the event of an emergency, I give the camp nurse permission to speak to my child's physician on my child's behalf.
- In the event of an emergency, I give permission to administer the following to my child (Please note: Medications must match name, frequency, and dosage as prescribed by the physician. Medications are to be supplied by parents with the exception of acetaminophen and ibuprofen.)

ALLERGY INFORMATION

Does your child have any allergies? Yes No (Please list allergies below)

No

MEDICATION ALLERGIES	FOOD ALLERGIES	HAYFEVER/SEASONAL
ANIMALS	DUST	OTHER

DIET INFORMATION

Does your child require a special diet?

Yes No

IF YES, PLEASE SPECIFY:

REVERSE SIDE TO BE COMPLETED BY A PHYSICIAN

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Personal Information (TO BE COMPLETED BY A PHYSICIAN)

CAMPER'S NAME

WAS EXAMINED AND FOUND TO BE IN SATISFACTORY HEALTH AND APPARENTLY FREE FROM COMMUNICABLE DISEASE. THERE ARE NO APPARENT INDICATIONS THAT THE CHILD SHOULD NOT PARTICIPATE IN ROUTINE CAMP ACTIVITIES. Yes No

Is the camper currently under medical treatment?

Yes No If yes, please explain:

Parent and Physician – Please Note: The Bureau of Child Development and Parent Education indicates that Section 2164 of the Public Health Law, amended, mandates pre-admission immunization against polio, measles, rubella and diphtheria. The only exceptions are those children with valid religious medical exemptions. Please indicate ALL doses and dates of immunizations.	DTP - 2, 4, 6, & 12 MONTHS	OPV - 2, 4, 6 MONTHS, 4-6 YEARS
	MMR - 12-15 MONTHS, 4-6 YEARS	HEB - BIRTH, 2, 6 MONTHS
	HIB - 1-2, 4 MONTHS, 1 YEAR	VARICELLA - 1 DOSE

Has the camper had any of the following?

Vision Exam Dental Inspection

PLEASE LIST ANY MEDICATIONS THIS CAMPER TAKES:	DO ANY MEDICATIONS NEED TO BE ADMINISTERED AT CAMP? <input type="radio"/> Yes <input type="radio"/> No	IF YES, PLEASE LIST SPECIFIC MEDICATIONS, DOSAGE AND FREQUENCY AND ATTACH A PRESCRIPTION
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AS A PHYSICIAN, PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT YOU FEEL IS IMPORTANT FOR OUR CAMP TO KNOW:

PHYSICIAN SIGNATURE	DATE:
ADDRESS	PHONE NUMBER: