

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 BUS. PHONE
FATHER'S NAME		FATHER'S BUS. PHONE
HOME PHONE	MOTHER'S CELLULAR OR BEEPER	FATHER'S CELLULAR OR BEEPER
FAMILY PHYSICIAN		PHONE
THERAPIST'S NAME		PHONE

IN CASE OF EMERGENCY

If we cannot be reached, please contact:

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
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- IN THE EVENT THAT MY FAMILY PHYSICIAN OR I CANNOT BE CONTACTED IN AN EMERGENCY, I HEREBY GRANT IVY LEAGUE DAY CAMP 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 IVY LEAGUE PERMISSION TO ADMINISTER THE FOLLOWING TO MY CHILD.

MEDICATION _____ DOSAGE _____ FREQUENCY _____

PARENT'S SIGNATURE
PARENT'S PERMISSION MUST MATCH EXACT MEDICATIONS, FREQUENCY AND DOSAGE AS PRESCRIBED BY PHYSICIAN. MEDICATIONS TO BE SUPPLIED BY PARENT WITH THE EXCEPTION OF ACETAMINOPHEN AND IBUPROFEN.

Does your child have any allergies? Yes No If yes, please list the allergy by category.

MEDICATIONS	FOODS
HAY FEVER	DUST
OTHERS	

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.

Is the camper currently under medical treatment? Yes No

IF SO, 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 or medical exemptions. Please indicate the dates of the most recent immunizations.	DTP - 2,4,6,12 MONTHS	OPV - 2,4,6 MONTHS, 4-6 YEARS
	MMR - 12-15 MONTHS, 4-6 YEARS	HEP B - BIRTH, 2, 6, MONTHS
	HIB - 1-2, 4 MONTHS, 1 YEAR	VARICELLA - 1DOSE

Physician, please check: Vision Exam Dental Inspection

PLEASE LIST ANY MEDICATIONS THIS CAMPER TAKES: _____

AS A PHYSICIAN, PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT YOU FEEL IS IMPORTANT FOR CAMP TO KNOW: _____

PHYSICIAN SIGNATURE		DATE
ADDRESS		PHONE
CITY	STATE	ZIP: