

NEW YORK STATE SHERIFFS INSTITUTE, INC.

2018 SUMMER CAMP APPLICATION

PLEASE FILL OUT IN BLUE INK ONLY

Week #: \_\_\_\_\_

CAMP HEALTH EXAMINATION FORM

This side to be filled in by parent (please print) or adult camper and checked with physician at time of examination

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_
Last First Middle Initial

Parent or Guardian: \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_
Street & Number City State Zip Code County

Email: \_\_\_\_\_

If not available in an emergency notify:

Name \_\_\_\_\_ Phone: \_\_\_\_\_
Area and Number

Street & Number City State Zip Code

Name \_\_\_\_\_ Phone: \_\_\_\_\_
Area and Number

Street & Number City State Zip Code

HEALTH HISTORY: (Check - giving approximate dates)

Convulsions \_\_\_\_\_ Behavior Issues \_\_\_\_\_ Chicken Pox \_\_\_\_\_
Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance

Operations or Serious Injuries (dates): \_\_\_\_\_

Chronic or Recurring Illness/Medical Issues: \_\_\_\_\_

Other Diseases or details of above: \_\_\_\_\_

Any allergies?: \_\_\_\_\_

Special Diet Information: \_\_\_\_\_

Any medications that will be brought to camp?: \_\_\_\_\_

Suggestions from Parents: \_\_\_\_\_

PARENT'S AUTHORIZATION

This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. In addition, I give my permission to the NYS Sheriffs' Association Institute, Inc. to use any pictures taken of my child while attending the summer camp.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**IMMUNIZATION HISTORY:**

PLEASE REFER TO THE ATTACHED SHEET PROVIDED BY THE NEW YORK STATE DEPARTMENT OF HEALTH FOR REQUIRED IMMUNIZATIONS.

\_\_\_\_\_ Diphtheria Toxoid - Containing Vaccine (DTP)

\_\_\_\_\_ Tetanus, Diphtheria, and Pertussis Booster (Tdap)

\_\_\_\_\_ Polio (IPV or OPV)

\_\_\_\_\_ Measles, Mumps, Rubella (MMR)

\_\_\_\_\_ Hepatitis B

\_\_\_\_\_ Haemophilus Influenzae type b (Hib)

\_\_\_\_\_ Varicella

\_\_\_\_\_ Meningococcal Vaccination (recommended/not required)

**TO BE FILLED OUT BY A LICENSED PHYSICIAN, PHYSICIAN ASST. OR NURSE PRACTITIONER.**

This examination must be performed **within 12 months** of arrival at camp. Physical Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

**CODE:** S - Satisfactory - X - Not Satisfactory - O - Not Examined

Hgt: \_\_\_\_\_ Wt: \_\_\_\_\_ BP: \_\_\_\_\_

Hgb. Test \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Eyes \_\_\_\_\_ Glasses: \_\_\_\_\_

Extremities \_\_\_\_\_

Ears \_\_\_\_\_

Posture (Spine) \_\_\_\_\_

Nose \_\_\_\_\_

Skin \_\_\_\_\_

Throat \_\_\_\_\_

Allergy \_\_\_\_\_

Teeth \_\_\_\_\_

Please Specify: \_\_\_\_\_

Heart \_\_\_\_\_

General Appraisal: \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Hernia \_\_\_\_\_

**(FOR GIRLS AND WOMEN):**

Has this person menstruated? \_\_\_\_\_

If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_

Special considerations: \_\_\_\_\_

**Recommendations and restrictions while in camp:**

Special Diet: \_\_\_\_\_

Special Medicine (name) (attached separate sheet if needed) \_\_\_\_\_

Swimming, diving \_\_\_\_\_

Strenuous activity \_\_\_\_\_

Other \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Telephone: \_\_\_\_\_  
Area code and Number

\_\_\_\_\_ M.D.  
Examining Physician

Date: \_\_\_\_\_

Date of Physical: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_