# NEW YORK STATE SHERIFFS' ASSOCIATION INSTITUTE, INC.
## 2016 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

**If not available in an emergency notify**:

- _____ Phone: _____
- Name Area and Number

_____
Street & Number City State Zip Code

- _____ Phone: _____
- Name Area and Number

_____
Street & Number City State Zip Code

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**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, Diptheria, 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_____ _____

Lungs _____ General Appraisal: _____

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: _____ _____ M.D.

Area code and Number Examining Physician

Date: _____ Date of Physical: _____

Address: _____

_____