LEGACY
Summer Camps

SUMMER MEDICAL FORM

Legacy is required by New York City Health Code to have a copy of the campers physical & immunization form stamped in order to participate in camp. Please note: physicals must be submitted with time so that it can be processed **BEFORE** the first day of camp by our membership office. We do not allow physicals to be accepted in person on the first day of camp.

General Information

- **If your child has** a physical completed already and will be valid during the time they will attend camp, please submit it to be reviewed. You will not need to schedule a physical with a physician.

- **If your child has** a physical that was submitted to their school which is already valid, please request the form from the school nurse and submit that form to us to be processed.

- **If your child does not** have a physical please schedule one with the doctor. Attached you will find our medical form which needs to be stamped and signed by the physician.

Submitting Forms:

- You may upload your medical forms using ProCare once your child is registered in camp.
- Once received, you will be sent a message on our ProCare App OR by email letting you know your physical is approved and cleared.

Physician must complete and sign this page of the Health Record- child's parent completes and signs the reverse (1st page) of this form.

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM LEGACY SUMMER CAMPS

CHILD'S LAST NAME	FIRST NAME	BIRTHDATE	SEX
		/ /	M ❑ F ❑

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes ❑ No ❑ (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

- ❑ Rheumatic Fever _____
- ❑ Seizures _____
- ❑ Diabetes _____
- ❑ Asthma _____
- ❑ Chicken Pox _____

Allergies

- ❑ Hay Fever _____
- ❑ Poison Ivy, etc. _____
- ❑ Insect Stings _____
- ❑ Penicillin _____
- ❑ Other Drugs _____
- ❑ Food _____

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____

Department of Health and Mental Hygiene — The City of New York — Bureau of Food Safety and Community Sanitation

DCR 7 (Rev. 2/04)

Physician must complete and sign this page of the Health Record- child's parent completes and signs the reverse (1st page) of this form.

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	Date _____

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

_____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

General Appraisal: _____

_____

_____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

_____ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____
ZIP CODE