Centro recreativo de Greenport

631-477-1133

Informe sanitario para: _____(Permiso #85124)

Apellido del niño/niña _____ Nombre_____Fecha de nacimiento_____
Sexo_____Domicilio _____ Teléfono_____

Historial de salud: (Marque dando fechas aproximadas)

Infecciones de oído _____ Fiebre del heno_____ Varicela_____

Fiebre reumática_____ Hiedra venenosa_____ Sarampión_____

Convulsión_____ Picaduras de insectos_____ Sarampión alemán_____

Diabético_____ Penicilina _____Paperas_____

Asma_____

Problemas de comportamiento_____

Medicamentos_____dosis_____

Hora/día: am/pm_____

Enfermedades contagiosas_____

cirugías/lesiones graves_____

Hospitalizaciones_____

Restricciones de movimiento_____

Aparatos que lleva (gafas, lentes, etc.)_____

Padres/Guardianes _____ Fecha_____

****Greenport Summer Day Camp - Examen físico - Debe ser remitido por un médico certificado****

Greenport Summer Day Camp-Physical Examination

Must be filled out by a Licensed physician

IMMUNIZATION HISTORY- This is a record of the dates of basic Immunization and most recent booster.

Diptheria Date_____Date_____ Date_____Date_____

Haemophilus influenza type B Date_____Date_____ Date_____Date_____

Hepatitis B Date_____ Date_____ Date_____Date_____

Measles/Mumps/Rubella Date_____ Date_____ Date_____Date_____

Poliomyelitis Date_____ Date_____Date_____Date_____

Tetanus Date_____

Varicella/Chicken Pox Date_____Date_____

EXAMINATION

General Appearance_____

Height_____**Weight**_____**Blood Pressure**_____**Posture and Spine**_____

Throat/tonsils_____ **Eyes**_____**Vision**_____ **With Glasses**_____**Heart**_____

Extremeties_____**Ears**_____**Hearing**_____**Feet**_____**Lungs**_____

Lungs_____ **Skin**_____**Nose**_____**Teeth**_____**Abdomen**_____

Neurological Findings_____

Allergy (specify)_____

Recommendations/restrictions for Camp_____

Special diet_____

Medications_____**MG**_____ **Times A Day**_____ **AM/PM**_____

General Appraisal_____

I Have examined the person herein described reviewed his/her health history and have found him/her physically able to engage in Day Camp activities except as noted above.

Examining Physician (Signature)_____ **Examining Physician (Please Print)**

Date_____**Telephone**_____ **Address**_____