MISS SUE'S SUMMER FUN
MEDICAL EXAM FORM 2017

RETURN BY APRIL 3, 2017

Miss Sue's Summer Fun
1191 Old Country Road
Plainview, NY 11803
516-938-0894 Fax: 516-938-3184

CHILD'S NAME:_____ **DOB:** _____

Parent Name: _____ **Parent Phone #:** _____

I have examined the camp applicant within the past year.

PHYSICIAN COMPLETE (*Actual Readings) ACTUAL DATE OF PHYSICAL: _____

*Height:	*Blood Pressure: *Pulse:
*Weight:	Abdomen:
Eyes:	Hernia:
Ears:	Heart:
Vision: w/glasses____ w/o glasses ____	Lungs:
Nose & Throat:	Urinalysis: Sugar: _____ Protein:_____ Blood:_____
Mouth & Teeth:	Orthopedic: *Scoliosis:
Skin:	Allergies: _____Seasonal _____Life threatening _____Asthma _____Medication

IMMUNIZATIONS AND TESTS

Immunizations	Date 1st Dose	Date 2nd Dose	Date 3rd Dose	Date 1st Booster	Date 2nd Booster
Polio					
DPT					
Tdap or TD					
MMR					
Measles					
Mumps					
Rubella					
Hib					
Hep B					
Hep A					
Varicella					
Pneumococcal					
PPD (Tuberculin)					
Meningococcal Vaccine					
Other					

Any Recommendations and/or Restrictions while at Camp. _____

Specify any history of Asthma, Diabetes, Seizures, Fainting, Bed Wetting, Psychological/Social problems, etc.

_____

The applicant is under the care of a physician for the following condition(s):

_____

Current treatment:

_____

Any medically prescribed meal plan or dietary restrictions:

_____

Any allergies (food, drugs, plants, insects, etc):

_____

Physician's Signature and Stamp_____

Address: _____ **Phone:** _____