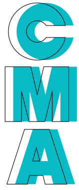

Children's Museum of the Arts
103 Charlton Street, New York NY 10014

2012 CAMP HEALTH & RELEASE RECORD

PAGE 1 TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PRESENTATION TO PHYSICIAN

________________________ ________________________ ___/___/___ Sex: M F

Child's Last Name First Name Birth Date

Home Address: ______________________________ **Phone** ______________

Parent/Guardian 1: ______________ Work #: ______________ Cell #: ______________

Parent/Guardian 2: ______________ Work #: ______________ Cell #: ______________

Physician's Name: ______________________________ Phone ______________

If Parent/Guardians are not available in an emergency, notify:

1. ______________________________ Phone ______________

My child has my permission to walk to/from the camp site and/or ferry by him/herself. ❑ Yes ❑ No

IMPORTANT: **Please notify the Program Manager if this child has been exposed to any communicable diseases three weeks prior to today's date.** Please state type of exposure: ______________________________

HEALTH HISTORY (Check, giving approximate dates)

	_____Ear Infections	_____Rheumatic Fever	_____Convulsion	_____Diabetes	_____Behavior
Allergies:	_____Hay Fever	_____Ivy Poisoning, etc.	_____Insect Stings	_____Penicillin	_____Food*
Diseases:	_____Chicken Pox	_____Measles	_____German Measles	_____Mumps	_____Asthma

_____ Food and/or Other (please explain) ______________________

Past Illnesses______________________

Contagious Illnesses______________________

Is child prone to head lice?______________________

Operations/Serious Injuries (dates)______________________

Hospitalization (dates)______________________

Chronic or Recurring Illness______________________

Other Conditions or Special Needs:______________________

Any specific activities restricted?______________________

CURRENT CONDITIONS

Medication(s) Taken:______________________

Appliances Worn (glasses, etc.):______________________

Conditions which modify activity (seizures, amnesia, heart conditions, etc.)______________________

Does family have medical insurance? q Yes q No Insurance Company: ______________ Policy # ______

Does family have Hospitalization Policy? ______________ Policy # ______________

PHOTO / TRIP RELEASE & CONSENT FOR EMERGENCY MEDICAL TREATMENT & MEDICATION

- I give permission for my child's picture to be used by Children's Museum of the Arts in promotional materials without compensation (e.g. calendar, brochure, video, website, etc.).
- I hereby give permission for my child to participate in all program activities and day trips as part of the Children's Museum of the Arts Art Colony program unless noted otherwise on this form.
- I hereby give authority to Children's Museum of the Arts camp staff to administer over-the-counter medication in the proper dosage to my child if needed (e.g.: Tylenol, Motrin, Benadryl, etc.) and to administer other medication as prescribed by a physician without my further consent. In case of emergency, I give

authority to Children's Museum of the Arts staff to obtain emergency treatment for my child with the understanding that the family will be notified as soon as possible, and I hereby authorize the doctor or the hospital to which my child may be brought (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment, and to administer an anesthetic to my child during his/her stay at Children's Museum of the Arts Art Colony camp.

By my signature, I hereby certify that all above information is approved and correct unless otherwise indicated.

Parent/Guardian (print name):________________________________ **Relationship to Child:**_____________________

Signature:____ **Date:**__________________

PHYSICAL EXAMINATION **TO BE FILLED OUT BY PHYSICIAN**

The purpose of this health record is to provide the staff with pertinent information that will help to serve the needs of this child in The Children's Museum of the Arts programs. **Attaching a printout of a recent physical examination is also acceptable.**

CHILD'S NAME (Last, First) ______________________________

IMMUNIZATION HISTORY: This is a record of dates of basic immunization and most recent booster doses. **According to New York State Law, a second MMR immunization must be administered to every child born before 1985.**

DPT or DT or TD	Date_____	Date_____	Date_____	Date_____	Date_____
Polio	Date_____	Date_____	Date_____	Date_____	Date_____
Measles	Date_____				
Rubella	Date_____				
Mumps	Date_____				
MMR 2	Date_____	Tuberculin Test Given_____ (most recent)			
Haemophilus Influenza Type B	Date_____				
Hepatitis B	Date_____	Date_____	Date_____		
Varicella (Chicken Pox)	Date_____				

MEDICAL EXAMINATION: **To Be Filled Out by Licensed Physician**

CODE: S = Satisfactory X = Not Satisfactory (explain) O = Not Examined

General Appearance:______________________________

Height ________	Eyes ________	Feet ________
Weight ________	Vision ________	Lungs ________
Blood Pressure ________	Glasses ________	Skin ________
Hgb. Test ________	Extremities ________	Nose ________
Urinalysis ________	Heart ________	Teeth ________
Posture & Spine ________	Ears ________	Abdomen ________
Throat-Tonsils ________	Hearing ________	Hernia ________
		Genitalia ________

Food Allergy: (Please Specify) ______________________________

Recommended Treatment/Action Plan:______________________________

____

Other Allergy: (Please Specify) ______________________________

Neurological Findings: ______________________________

Describe Abnormal Findings and/or Handicapping Conditions: ______________________________

____

Has child ever received products containing horse serum?: ______________________________

RECOMMENDATIONS AND RESTRICTIONS WHILE IN THE PROGRAM:

Special Diet: ______________________________

Special Medication: ______________________________

Will special medication need to be administered to child at camp? If so, explain: ______________________________

If yes, directions for use: ______________________________

Swimming ________ Diving ________

Strenuous Activity ______________________________

General Appraisal/Comments: ______________________________

____

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 Children's Museum of the Arts Art Colony camp activities, except as noted above.

______________________________M.D. Date of Examination: ______________________________

Examining Physician

Address: ______________________________ Telephone: ______________________________

City, State Zip Code