

Directors:
 Donna Fiedler
 Kenneth Fiedler
 Scott Fiedler

Associate Directors:
 Jo Korder
 Ken Korder



FEMALE CAMPER MEDICAL FORM

TO BE COMPLETED BY PARENT:

Child's Name: _____ Date of Birth: _____

Address: _____ Telephone: Day: (____) _____

Evening: (____) _____

Cell: (____) _____

Pertinent Past Medical History:

- Ear Infections
- Seizure Disorder
- Pneumonia

Please Check all that apply

- Eyeglasses/Contacts
- Heart Disease Defect
- Diabetes
- Asthma
- Headaches
- Nose Bleeds

Special Medication (if any):

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parent(s) or guardian of campers. In the event I cannot be reached, I hereby give permission to the physician selected by Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

****Parent's Signature:** X _____ **Date:** _____

TO BE COMPLETED BY PHYSICIAN:

History:

Allergies:

Immunization History:

	Diphtheria, Pertussis, Tetanus		Trivalent - Polio Vac.		Type	Date	Tests		
	Dose	Date	Dose	Date			Date	Type	Result
1					Measles		Hb.		
2					Rubella		Electro		
3					Mumps		Hb/Hct		
4					Measles		Lead		
					Mumps		Urine		
					Rubella		Vision	R	L
							Hearing	R	L

Girl Menstruates: Yes ___ No ___

Physical Exam:

Physical Exam Findings:

(Diagnosis): _____

A. If normal, please check _____ Height: _____ Weight: _____

B. Abnormal Findings: _____

Name of Physician (Please print or use rubber stamp): _____

Address: _____

Telephone: (____) _____

Physician's Signature: _____ Date: _____

Winter Office:

3242 Judith Lane, Oceanside, NY 11572
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Summer Office:

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