DRIFTWOOD DAY CAMP
MEDICAL EXAM FORM 2017

RETURN BY March 1, 2017

Driftwood Day Camp
331 Mount Misery Road
Melville, NY 11747
631-692-6990 Fax: 631-692-4140

CHILD'S NAME:_____ **DOB:** _____
DATE OF PHYSICAL: _____

PHYSICIAN COMPLETE **(*Actual Readings)**

*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	Date	Date	Date	Date
	1st Dose	2nd Dose	3rd Dose	1st Booster	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 medications:

_____

Any medically prescribed meal plan or dietary restrictions:

_____

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

_____

Physician's Signature and Stamp_____

Address: _____ **Phone:** _____