Poughkeepsie Day School

Student Summer Camp Health Form 2018

To be filled out by the student's health care provider

- New York State Public Health Law requires campers within one year prior to date of program. Health examinations may not pre-date September 7, 2017.
- This **completed form must be returned to PDS** via e-mail- camp@poughkeepsieday.org, or by mail to: Summer program, PDS, 260 Boardman Road, Poughkeepsie, NY 12603 one week before start of date of camp.
- All sections of the form must be filled out; incomplete forms will be considered invalid and will be returned. Students whose completed form has not been received will not be permitted to attend camp. Immunization form from doctor may be used.

Name_____ **Birth date**_____

Vision: R _____ L_____ **Audiogram:** normal _____ BP _____

Corrected: R _____L_____ abnormal _____

__ Not tested __ Not done

Height_____ **Weight**_____ **Scoliosis**_____

Allergies_____

Medications taken at home* _____

*For medications to be administered at school, please submit a permission form for prescription and non-prescription medications (enclosed).

Immunization record ➔ (please turn over to complete) ➔

I have examined the child named above. In addition, I have reviewed the health history and immunization records. There are no apparent contraindications to participation in routine school and/or competition sports. Physical exam is within normal limits.

Exceptions, comments, special problems, etc.

_____ _____

Physician signature *Date of exam*

(Please complete page 2)

VACCINE	Date Given (mm/dd/yr)	Vaccine Administrator Initials	Dose
Hib 1			
Hib 2			
Hib 3			
DTP/Hib 1 Combination			
DTP/Hib 2 Combination			
DTP/Hib 3 Combination			
DTP/DTaP 1			
DTP/DTaP 2			
DTP/DTaP 3			
DTP/DTaP 4			
DTP/DTaP 5			
DT Pediatric			
Td Adult			
OPV/VIPV 1			
OPV/VIPV 2			
OPV/VIPV 3			
OPV/VIPV 4			
MMR 1			
MMR 2			
Varicella			
Hep B 1			
Hep B 2			
Hep B 3			
Human Papilloma Virus			
(HPV) **Dose 1**			
(HPV) **Dose 2**			
(HPV) **Dose 3**			
Meningococcal			
(MCV4) **Dose 1**			
(MCV4) **Dose 2**			

TEST	Date
Mantoux	
Lead Screening	

Tuberculin (PPD) Tine Test

Date: _____/_____/_____

Result: _____ minimum duration

If skin test is positive:

CXR date: _____/_____/_____
(Please provide copy of CXR report)

TB therapy initiated? ☐ Yes ☐ No

BCG date: _____/_____/_____

☐ This student is at low risk for TB. *(PPD required, regardless of prior BCG vaccination)*

Physician Stamp