Poughkeepsie Day School

Student Summer Camp Health Form 2019

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, 2018.
- 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.

Name_____ **Birth date**_____

Vision: R _____ L_____
Corrected: R _____L_____
__ Not tested

Audiogram: normal _____ BP _____
abnormal _____
__ 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