

EDWARD P. MANGANO
COUNTY EXECUTIVE



BRIAN NUGENT
CHIEF DEPUTY
COMMISSIONER

COUNTY OF NASSAU
DEPARTMENT OF PARKS, RECREATION & MUSEUMS
EISENHOWER PARK - EAST MEADOW, NEW YORK 11554
www.nassaucountyny.gov/parks

Nassau County Summer Recreation Program 2015
Physician's Report

The camper's physician must complete both sides of this form and the accompanying Standing Orders sheet.

Please return to the camp office by May 1st. All information will be held in the strictest confidence; please be as thorough as possible.

Child's name: _____
Date of Birth: _____
Date: _____ **Weight:** _____ **Height:** _____
Blood Pressure: _____ **Urine:** _____ **Hematocrit:** _____

Health Care Recommendations by Licensed Physician

I have examined the child within the past year.

Date examined: _____

The NY Department of Health requires that a physical exam was completed no more than a year prior to the last day of camp, August 6th.

Is the camper able to participate in an active camp program? Yes _____ No _____

Camper is under the care of a physician for the following condition(s): _____

Current treatment (include current medications): _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Are there any...

Allergies (food, drugs, plants, insects, etc.)? _____

If yes, should exposure occur, how should the allergic reaction be treated? If this is an anaphylactic response, will this child's parents supply an epinephrine device? _____

Cardiovascular conditions? _____

Respiratory conditions? _____

Middle ear conditions? _____

Gastrointestinal conditions? _____

Please complete both sides of this form.

Please Return this form upon completion to:
Eisenhower Park, Summer Recreation Program
1899 Hempstead Turnpike
East Meadow, NY 11554
516-572-0245
Fax 516-572-0236

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Child's Name: _____

Are there any...

Activity restrictions? _____

Neurological conditions? _____

Orthopedic conditions? _____

Special diet? _____

Treatment(s) to be continued at camp? _____

Medication(s) to be administered at camp? _____

Same as during the school year? _____

Additional medical or psychological conditions not listed that we should be aware of? _____

Camper Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines Year of Basic Immunization Year of Last Booster

DPT Series, Diphtheria, Pertussis,

Tetanus **OR**

1

2

3

1

2

3

TD Series, Tetanus, Diphtheria **OR**

Tetanus

Polio Series

MMR Series

HIB Series

Hepatitis B Series

Chicken Pox (illness or vaccine)

Meningitis

Other

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments. Thank you for helping us to provide a successful summer experience for this camper!

Licensed Physician's Signature _____

Physician's Printed Name _____

Physician's Address _____

Phone _____

Street City, State, Zip Area Code/Number

Date of Form Completion _____

*By _____

**Initial if completed by nurse or physician's assistant.*