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

# Nassau County Summer Recreation Program 2020
# 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.*