TOWN OF STRATFORD

offering more from forest to shore

MEDICAL FORM

Child's Name ______________________________________ Sex ___ M ___F

Address ____ Birth date _________

City ____________________________ State ________ Zip Code __________

PARENT INFORMATION:

Mother ______________________________Father ______________________

Employer ____________________________Employer______________________

Phone _______________________________Phone _______________________

IN CASE OF EMERGENCY NOTIFY:

Name _______________________________ Phone ______________________

Name _______________________________ Phone ______________________

HEALTH HISTORY:

DISEASES	**ALLERGIES**	**CHRONIC/RECURRING ILLNESS**
Chicken Pox _______	Hay Fever ________	Ear Infections_______________
Measles ___________	Asthma __________	Heart Disease _______________
German Measles ____	Drugs ____________	Convulsions ________________
	Ivy Oak __________	Diabetes ___________________
	Food ____________	Behavioral _________________
	Bee Stings ________	
	Insect Stings ______	

MEDICAL NOTES: PLEASE COMMENT ON ABOVE ANSWERS AS WELL AS ANY OPERATIONS, INJURIES OR SPECIAL RESTRICTIONS:______________________

____

AUTHORIZATION:

This health history is correct so far as I know, and the person named above has permission to participate in all activities except noted by me or the examining physician.

In the event I cannot be reached in case of accident or sudden illness furing activities which would require more than basic First Aid Treatment, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child named above.

PARENT/GUARDIAN SIGNATURE: ____

DATE: ____________________

PHYSICAL MUST BE COMPLETED WITHIN TWO YEARS OF THE PROGRAM START DATE

TO BE FILLED OUT BY THE PHYSICIAN:

Child's Name ____

IMMUNIZATION DATE	BOOSTER DATE
DPT ______________________________	____
POLIO_____________________________	____
HB ________________________________	____
MMR ______________________________	____
TB TEST ___________________________	TYPE ___________________________________
TETANUS___________________________	____

TEST CODES: SATISFACTORY –S	NOT SATISFACTORY – X	NOT EXAMINED - 0
URINALYSIS ___________________	BLOOD COUNT _________	EYES _____________
TEETH _______________________	EXTREMITIES __________	GLASSES __________
HEART _______________________	POSTURE (SPINE) _______	EARS ______________
LUNGS _______________________	SKIN ___________________	NOSE _____________
ABDOMEN _____________________	ALLERGY _______________	THROAT ___________
HERNIA ______________________	OTHER ____	

GENERAL APPRAISAL:

____

____

RECOMMENDATIONS AND RESTRICTIONS:

SPECIAL DIET ____

SPECIAL MEDICINE ____

IS PARENT SENDING IT? ____

SWIMMING, DIVING ____

STRENUOUS ACTIVITY ____

OTHER ____

I have examined the person herein described and have reviewed his/her health history. It is my opinion he/she is physically able to engage in camp activities, except as noted.

Exam Date ___________________________________

Physician Signature ______________________________ License # _________________________

Print Physician Name ____

Address ____