PS 87 Afterschool Program

Sponsored by the PS 87 Parents Association

160 West 78 Street New York NY 10024 Phone 212-873-0490

www.87afterschool.org

Medical Information Form

Date of Examination: _____

To be completed by Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child: _____ Date of Birth: _____
Home Address: _____ Phone: _____
Parent or Guardian: _____ Cell: _____
Emergency Contact: _____ Phone: _____
Important:

Please notify the Afterschool Program if participant is exposed to any communicable disease during the three weeks prior to program attendance: Yes _____ No _____
(If yes, state type of exposure: _____)

Health History: (Check, giving days as appropriate)

Please list any allergies, including food and environmental, or any medical conditions that our Day Camp staff should know about:

Conditions	Allergies	Has your child had:
Frequent Ear Infections _____	Hay Fever _____	Chicken Pox _____
Asthma _____	Insect Stings _____	Measles _____
Frequent Colds _____	Penicillin _____	Mumps _____
Diabetes _____	Food _____	Other _____
Behavior _____	_____	
Other _____	Other _____	

Medical Examination

This examination should be performed within 12 months of arrival at Afterschool.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
O = Not Examined

General Appearance _____

Height _____ Weight _____ Blood Pressure _____ Hgb. Test _____

Urinalysis _____ Posture & Spine _____ Throat – Tonsils _____

Eyes _____ Vision _____ Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____ Feet _____ Lungs _____ Skin _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____

Genitalia _____

Allergy: (Please Specify) _____

Neurological Findings _____

Describe abnormal findings and / or handicapping conditions _____

_____

Is this child limited from participating in any Afterschool activities? (including gym play and outdoors activities)._____

Immunizations

DPT / DT	1st Date	2nd Date	3rd Date	Booster Date	Booster Date
Polio / OPV	1st Date	2nd Date	3rd Date	Booster Date	Booster Date
Hib (conjugated preferred)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
MMR	1st Date	2nd Date			
Varicella / Chicken Pox	1st Date	2nd Date			
Tetanus Booster					

Other Immunizations

Type of Immunization:	Date:
Type of Immunization:	Date:

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

_____M.D.
EXAMINING PHYSICIAN

_____
DATE

OFFICE STAMP

Name of Examination Physician (Print) _____

Address _____ Zip Code _____

Telephone _____ Fax _____