

Raritan Recreation Medical History Report

Note: Day camps require the same medical information and immunizations as school enrollment. We will accept a copy of BRRSD Physical Examination Records as long as it up to date for the child's age and immunizations are attached.

Child Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City, State, Zip: _____

Phone: _____

Physician: _____ Phone: _____ Fax: _____

Past Medical History: Parent/Guardian to complete and Physician/Medical Provider to Review

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Earache | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds (Freq.) | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colitis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> _____ |

Other/Explain _____

Known Allergies: _____

Medications Currently in Use: _____

Past Surgical History: Tonsillectomy Appendectomy Cholecystectomy

Herniorrhaphy Other _____

Permission is granted for the camp director/health director or operator to share this information with camp staff on a "need to know" basis.

Signature of Parent/Guardian

Date

Child Name: _____ DOB: _____

The following information to be completed by physician or medical provider

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm: _____

Vision: R 20/ _____ L 20/ _____ Corrected: Yes / No Contacts: Yes / No Glasses: Yes / No

Pupils: Equal _____ Unequal _____ Hearing: R _____ L _____

Indicators:	Normal:	Abnormal Findings:	Initials:
Head/Neck	Yes / No		
Eyes/Sclera/Pupils	Yes / No		
Ears	Yes / No		
Mouth/Nose/Throat	Yes / No		
Heart: Murmur/Rhythm	Yes / No		
Lungs: Auscultation/Percussion	Yes / No		
Chest Cotnour	Yes / No		
Skin	Yes / No		
Abdomen: Assessment (Include Liver, Spleen)	Yes / No		
Tanner Stage: Testes/Onset of Menses	Yes / No		
Hernia	Yes / No		
Neck/Back/Spine: Range of Motion	Yes / No		
Scoliosis	Yes / No		
Upper Extremities	Yes / No		
Lower Extremities	Yes / No		
Neurological: Balance and Coordination Romberg	Yes / No		
Heel Walk	Yes / No		
Tandem Walk	Yes / No		
Toe Walk	Yes / No		
Nose Touch	Yes / No		

Additional Observations: _____

Please attach copy of current immunizations

Clearance: A. Child may participate in physical activity: Yes / No
B. **Not Cleared** for physical activity

Diagnosis: _____

Recommendations: _____

Provider's Signature: _____

Date: _____



Physician/Provider's Stamp