

**KENWAL DAY CAMP**  
**100 Drexel Ave**  
**Melville, New York 11747**  
**Tel 631.694.3399 Fax 631.694.3841**

**MEDICAL EXAMINATIONS: TO BE FILLED OUT BY A LICENSED PHYSICIAN.** This examination should be performed prior to the start of camp. Examination for some other purpose within this period of time is acceptable. This examination is for determining fitness to engage in strenuous activities.

Name \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

Hgt \_\_\_\_\_ Wgt \_\_\_\_\_ Extremities \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_

Teeth \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Posture (spine) \_\_\_\_\_ Skin \_\_\_\_\_

ALLERGIES/specify \_\_\_\_\_

GENERAL APPRAISAL \_\_\_\_\_

ARE ALL IMMUNIZATIONS UP TO DATE?

DPT series \_\_\_\_\_ Booster \_\_\_\_\_ Tetanus Booster \_\_\_\_\_ Typhoid \_\_\_\_\_ Polio \_\_\_\_\_ Booster \_\_\_\_\_

Tuberculin Test \_\_\_\_\_ Measles Vaccine(Live) \_\_\_\_\_ German Measles (Rubella) \_\_\_\_\_ Mumps )Vaccine) \_\_\_\_\_

Haemophilus Influenza type b \_\_\_\_\_ Hepatitis b \_\_\_\_\_ Varicella(Chicken Pox) \_\_\_\_\_

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITES, EXCEPT AS NOTED.

DATE \_\_\_\_\_ EXAMINING PHYSICIAN \_\_\_\_\_

TELEPHONE \_\_\_\_\_ ADDRESS \_\_\_\_\_

**\*\*TO BE COMPLETED BY PARENT OF GUARDIAN\*\***

I hereby give permission to the Camp Kenwal nurse to dispense children's Tylenol to my child where she deems it necessary in the event that I cannot be reached.

YES \_\_\_\_\_ NO \_\_\_\_\_ PARENTS SIGNATURE \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONEEL SELECTED BY THE CAMP DIRECTOR TO ORDER X-RAYS, ROUTINE TESTS.TREATMENT AND NECESSARY TRANSPORTATION FOR ME/OR MY CHILD. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR MY CHILD AS NAMED ABOVE. THE COMPLETED FORMS MAY BE PHOTOCOPIES FOR TRIPS OUT OF CAMP.

\_\_\_\_\_  
PARENT OR GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE