



St. Vincent de Paul Camp



1298 Main Street, Buffalo, New York 14209
Phone (716) 882-3360, ext. 7 • Fax (716) 882-3556

RESIDENTIAL AND DAY CAMPERS

HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

Address: _____

Gender: M F Emergency Contact: _____ Emergency Phone: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 Filled out on back of form

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral: Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Specify current disease: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5th. <input type="checkbox"/> 5th. through 49th. <input type="checkbox"/> 50th. through 84th.	Vision - Near Point	R	L	
<input type="checkbox"/> 85th. through 94th. <input type="checkbox"/> 95th. through 98th. <input type="checkbox"/> 99th. and higher	Hearing Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____
Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all) None Additional medications listed on reverse of form Are you sending medication to camp
Name: _____ Dosage/Time: _____
Name: _____ Dosage/Time: _____

Note: All medications must be in original container with the original label. Only properly labeled medication will be administered by camp nurse. All medications are to be turned in to the camp nurse.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor
 Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

Has Your Child Ever Had: (If yes, please give date)

	YES	Date	NO		YES	Date	NO		YES	Date	NO
Mumps				Heart Disease				Head Injury			
Measles				Kidney Problems				Hemophilia			
Hepatitis				Epilepsy				Diabetes			
Freq. Strep Throat				Ear Infection				Hernia			
Mononucleosis				Dizziness				Other			
Asthma				Migraine							
Emotional Problems				Contact with TB							

Important: Please notify the camp office if the child is exposed to any communicable disease during the three weeks prior to camp attendance.

Immunization Information: State law mandates immunizations against diphtheria, polio, measles, mumps, and rubella before a child may attend camp. Please list all dates available for each immunization. Information must be verified by "shot" records signed by one of the following: a physician, physician's assistant, nurse practitioner, registered nurse.

• ONLY A LICENSED HEALTH PROFESSIONAL MAY COMPLETE THIS SECTION •

IMMUNIZATIONS

If one or more of the required immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption statement at the bottom of form.

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP							
TD (tetanus/diphtheria)							
Tetanus							
Polio							
MR.							
or Measles							
or Mumps							
or Rubella							
Haemophilus influenza B							
Hepatitis B							
Varicella (chicken pox)							
BCG							

Which of the following has the participant had?

- _____ Measles
- _____ Chicken Pox
- _____ German Measles
- _____ Mumps
- _____ Hepatitis

TB Mantoux Test

Test Date: _____

Result: _____

Standard Over the Counter/PRN Medications: (The following medications are available in the infirmary and will be administered at the discretion of a RN, if approval is indicated by the camper's physician.)

Drug Name	Route	Dosage	Schedule	Physician Approval	Comments
Chloroseptic	Liquid	per label	sore throat	Y N	
Cough Drops	Lozenges	per label	sore throat	Y N	
Immodium	Liquid, Caplets	per label	diarrhea	Y N	
Children's Mylanta	Liquid, Chewables	per label	upset stomach	Y N	
Neosporin	Topical Oint.	per label	cut, scrapes	Y N	
Ora-jel	Ointment	per label	tooth/mouth pain	Y N	
Acetaminophen	Liquid, Pills	per label	fever, pain relief	Y N	
Benadryl	Chewable, Pills	per label	allergic reaction	Y N	
Robitussin	Syrup	per label	cough	Y N	
Artificial Tears		per label	minor eye irritations	Y N	

I also have checked the above OTC/PRN Medications that the above child is allowed be administered at camp if need be. On the basis of my finding as indicated above on my knowledge of the above child, I find that: (s)he is free from contagious and communicable disease Yes No and is able to participate in camp Yes No

Signature of Physician/Physician Assistant/Nurse Practitioner

Address

Name (please print)

City, State, Zip

Title

Phone

Date

Permission to Provide Necessary Treatment or Emergency Care

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related 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 the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____