



# Beaver Lake Day Camp Health Form

## TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
City/Borough	State	Zip Code	School/Center/Camp Name			District Number _____	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Parent/Guardian Last Name <input type="checkbox"/> Foster Parent		First Name		Email		

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ <b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____ <i>Attach MAF if in-school medications needed</i>		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check at current medication(s): Asthma Control Status _____ <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability <i>Explain all checked items above.</i>				<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Addendum attached.			
<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____ Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____		<b>General Appearance:</b> <input type="checkbox"/> Physical Exam WNL NI Abn <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine Describe abnormalities: _____				<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____			

<b>DEVELOPMENTAL (age 0-6 yrs)</b> Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____ Describe Suspected Delay or Concern: _____		<b>Nutrition</b> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____		<b>Hearing</b> Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abn <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abn <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry _____ <input type="checkbox"/> NI <input type="checkbox"/> Abn <input type="checkbox"/> Referred																			
<b>SCREENING TESTS</b> Date Done ____/____/____ Results Blood Lead Level ( BLL ) (required at age 1 yr and 2 yrs and for those at risk) _____ μg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) _____ <input type="checkbox"/> Not at risk — Child Care Only — Hemoglobin or Hematocrit _____ g/dL _____ %		<b>Vision</b> Date Done ____/____/____ Results <3 years: Vision appears: _____ <input type="checkbox"/> NI <input type="checkbox"/> Abn Acuity (required for new entrants and children age 3-7 years) _____ Right _____ _____ Left _____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No		Report only positive immunity: <table border="1"> <tr><th>IgG Titers</th><th>Date</th></tr> <tr><td>Hepatitis B</td><td>____/____/____</td></tr> <tr><td>Measles</td><td>____/____/____</td></tr> <tr><td>Mumps</td><td>____/____/____</td></tr> <tr><td>Rubella</td><td>____/____/____</td></tr> <tr><td>Varicella</td><td>____/____/____</td></tr> <tr><td>Polio 1</td><td>____/____/____</td></tr> <tr><td>Polio 2</td><td>____/____/____</td></tr> <tr><td>Polio 3</td><td>____/____/____</td></tr> </table>		IgG Titers	Date	Hepatitis B	____/____/____	Measles	____/____/____	Mumps	____/____/____	Rubella	____/____/____	Varicella	____/____/____	Polio 1	____/____/____	Polio 2	____/____/____	Polio 3	____/____/____
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Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No CIR Number _____ Physician Confirmed History of Varicella Infection <input type="checkbox"/>		<b>IMMUNIZATIONS - DATES</b>	
DTP/DTap/DT Td Polio Hep B Hib PCV Influenza HPV		Tdap MMR Varicella Mening ACWY Hep A Rotavirus Mening B Other _____	

<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	
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Health Care Practitioner Signature _____ Date Form Completed ____/____/____ Health Care Practitioner Name and Degree (print) _____ Practitioner License No. and State _____ Facility Name _____ National Provider Identifier (NPI) _____ Address _____ City _____ State _____ Zip _____ Telephone _____ Fax _____ Email _____	
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