Keiki Explorers Club Medical Form

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Keiki Explorers Club programs.

To be filled out by camper's physician

Name of Camper: ______________________ Name of Physician: ___________________

Immunization History

Please provide us with a record of basic immunization and most recent booster doses for the camper listed above.

Dtap, DTP, DT, TD	Date __________	Date __________	Date __________	Date __________	Date __________
Polio	Date __________	Date __________	Date __________	Date __________	Date __________
Measles	Date __________	Date __________	Date __________	Date __________	Date __________
Rubella	Date __________	Date __________	Date __________	Date __________	Date __________
Mumps	Date __________	Date __________	Date __________	Date __________	Date __________
Hib	Date __________	Date __________	Date __________	Date __________	Date __________
Hepatitis B	Date __________	Date __________	Date __________	Date __________	Date __________
Varicella	Date __________	Date __________	Date __________	Date __________	Date __________
PCV	Date __________	Date __________	Date __________	Date __________	Date __________

Date of most recent Tetanus Shot ______________

PPD-MANTOUX Date Read ______________

Most Recent Tuberculin Test Given _______________ Result _____________

MEDICAL EXAMINATION (To be completed by licensed Physician)

EXAMINATION IS ACCEPTABLE WHEN PERFORMED NO MORE THAN 12 MONTHS PRIOR TO ARRIVAL AT CAMP.
CODE: S = SATISFACTORY X = NOT SATISFACTORY (EXPLAIN) O = NOT EXAMINED

GENERAL APPERANCE ____

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 _________

ALLERGIES (PLEASE SPECIFY):____

NEUROLOGICAL FINDINGS:____

DESCRIBE ABNORMAL FINDINGS AND/OR HANDICAPPING CONDITIONS:

____

RECOMMENDATION AND RESTRICTIONS DURING CAMP

Special Diet ____
Special Medicine Needed ____
Strenuous Activity ____
General Appraisal ____

DOCTOR'S RELEASE

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 all Chelsea Piers Summer Sports Camp activities, except as noted above.

Examining Physician Signature ____
Physician Name (please print) ____
Address____ Zip Code ______________ Telephone_______________
Date of Examination ____________________________________

PLEASE MAIL COMPLETED FORM TO:

Keiki Explorers Club • 41 Watchung Plaza #266 • Montclair, NJ 07042 or email: keikiexplorers@gmail.com