

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DIVISION OF ENVIRONMENTAL HEALTH
BUREAU OF FOOD SAFETY AND COMMUNITY SANITATION
253 BROADWAY, 12TH FLOOR, CN 59A
NEW YORK, N.Y. 10007
(212) 676-1600

Below is the recommended written statement that must be provided by each camp to all parents or guardians declaring that the camp is licensed by the New York City Department of Health and Mental Hygiene. (NYCHC Section 48.29).

PARENT INFORMATION STATEMENT

Plymouth Day Camp

(Name of Camp)

75 Hicks Street Brooklyn, NY 11201

(Address)

This camp is licensed by the New York City Department of Health and Mental Hygiene and is inspected twice yearly. The inspection reports are filed at the Bureau of Food Safety and Community Sanitation.

PLYMOUTH DAY CAMP
Emergency Contact Information

Child: _____

Class: _____

Address: _____

Home telephone: _____

E-mail Address: _____

Mother's Name: _____
Employer: _____

Cell Phone #: _____
Telephone #: _____

Father's Name: _____
Employer: _____

Cell Phone #: _____
Telephone #: _____

Please list three persons to contact in case of emergency (other than parent):

1. Name: _____ Telephone #: _____ Cell Phone #: _____
Relationship to Child: _____

2. Name: _____ Telephone #: _____ Cell Phone #: _____
Relationship to Child: _____

3. Name: _____ Telephone #: _____ Cell Phone #: _____
Relationship to Child: _____

Name of Physician and/or Hospital: _____
Address: _____ Telephone #: _____

Please list any special medical conditions or allergies below. Please include treatment, if any:

Please sign the statement below and return it to your child's counselor.

CONSENT FOR EMERGENCY MEDICAL TREATMENT (required for admission)

I do hereby give authority to the Plymouth Day Camp staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED: _____ DATE: _____
RELATIONSHIP: _____

Plymouth Day Camp
75 Hicks Street
Brooklyn, NY 11201

Camp Dismissal Instructions

My child, _____ in the _____ Room

will be picked up on a regular basis by:

Full name: _____

Relationship to child: _____

My child may also be picked up occasionally by the following people:

Full name:

Relationship to child:

1. _____

2. _____

3. _____

Please notify the office or your child's counselor if there is a change in your pickup instructions.

My child _____ accompany members of his/her group and the
(may/may not)
counselors on neighborhood walking trips.

(Parent's signature)

(Date)

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

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 Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)	Date _____	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	Date _____

MEDICAL EXAMINATION – To be filled out 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)
- 0 = Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

Allergy: (Please specify) _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

General Appraisal: _____

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 Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

M.D.
EXAMINING PHYSICIAN (SIGNATURE)

PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____

ZIP CODE

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS
 (This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

CHILD'S LAST NAME _____	FIRST NAME _____	BIRTHDATE _____ / _____ / _____	SEX M <input type="checkbox"/> F <input type="checkbox"/>
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Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
 Yes No (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

Allergies

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Poison Ivy, etc. _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Other Drugs _____ |
| | <input type="checkbox"/> Food _____ |

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____

Department of Health and Mental Hygiene — The City of New York — Bureau of Food Safety and Community Sanitation