****

**To be Completed by Physician
Child Health & Immunization Form
Forms must be handed in to the Camp Director by May 15th**

Childs Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Work or Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DTap or DT Hib PCV Influenza Varicella Heb B
1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_

**Physician MUST fill in box:**
PARTICIPATION IN:

 Regular Activities

Strenuous Activities

Swimming/Diving

Any Restrictions?

MMR Heb A Rotavirus IVP
1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_
 3. \_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_
Weight \_\_\_\_\_\_\_\_\_\_\_\_\_
BP \_\_\_\_\_\_\_\_\_\_\_\_\_
Eyes \_\_\_\_\_\_\_\_\_\_\_\_\_
Ears \_\_\_\_\_\_\_\_\_\_\_\_\_
Lymph Nodes \_\_\_\_\_\_\_\_\_\_\_\_\_ Nutrition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Urinalysis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Orthopedic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Nose \_\_\_\_\_\_\_\_\_\_\_\_\_ Scoliosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Tonsils \_\_\_\_\_\_\_\_\_\_\_\_\_
Heart \_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Lungs \_\_\_\_\_\_\_\_\_\_\_\_\_ Nervous System\_\_\_\_\_\_\_\_\_\_\_\_
Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_
Thyroid \_\_\_\_\_\_\_\_\_\_\_\_\_ Speech\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Skin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Instructions, Allergies, Specific Medication Orders Etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sportsplex New Windsor \* 2902 Route 9W, New Windsor, NY 12553 \* 845-565-7600 \* Fax: 845- 448-0952
 www. Sportsplex-nw.com

****

**To be Completed by Parent or Guardian
Medical History
Forms must be handed in to the Camp Director by May 15th**

Childs Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has your child ever had? Chicken Pox \_\_\_\_\_\_ Pneumonia \_\_\_\_\_\_\_\_

Is your child subject or ever been treated for: Fainting Spells \_\_\_\_\_ Headaches\_\_\_\_\_\_\_ Tonsilitis\_\_\_
Abdominal Pains\_\_\_\_ Fractures\_\_\_\_\_\_\_\_ Concussions\_\_\_\_\_\_\_ Hernia \_\_\_\_\_\_\_\_\_\_

If yes, Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child prone to; Ear Infections \_\_\_\_\_\_\_\_\_\_ Sinus Infections \_\_\_\_\_\_\_\_\_\_\_\_ Lung/Kidney Disorder\_\_\_\_\_\_\_\_\_\_
Has your child been treated for any difficulties relating to the heart: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to any medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Does your child have any allergies (food or environmental) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Is your child currently taking any medications, if yes what is the medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
If your child is taking medication during camp, please send in a note from a physician to authorize camp personnel
to store and distribute the medication during the day.

Will you allow counselors to apply sunscreen to your child: (Please circle one) Yes or No

Does your child have experience swimming?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Any restrictions for swimming?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Any restrictions for physical activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has your child ever attended camp Sportsplex before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please describe any other concerns, or information that you feel would help is be responsive to your child’s needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 I understand that my signature here as a parent or legal guardian indicates that all the above information is correct., that my child is in satisfactory health with no specific health problems other than those noted above, that I agree to comply with all program polices and that I give permission for mu child to participate in all program activities. I also give permission, in case of injury, for medical personnel to administer first aid/treatment when the need for such treatment is immediate and efforts to contact persons are unsuccessful, and to take my child to the hospital for treatment if necessary.
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
All information provided on this form will remain confidential.

NEW YOK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**COVID-19** **Health Screening Attestation**

The New York State Department of Health Interim Guidance for Child Care Programs requires all individuals to complete a daily health screening questionnaire before arriving to a child care program or upon arrival to a child care program.

If an individual answers “Yes” to any of the screening questions, they cannot enter the child care program, except as otherwise indicated.

**Screening** **Questions:**

1. Is your temperature higher than or equal to 100.4 degrees Fahrenheit?

2. Have you had any known close or proximate contact with a person confirmed (by diagnostic test) or suspected (based on symptoms) to have COVID-19 in the past 10 days? Note: Close contact is defined by DOH as being within 6 feet of an individual for 10 minutes or more within a 24-hour period, starting from 2 days before symptom onset or, if asymptomatic, 2 days before the date the positive sample was collected through when they are isolated. Close contact does not include individuals who work in a health care setting wearing appropriate, required personal protective equipment.

Exception: Asymptomatic staff and children may attend if the staff/child is fully vaccinated or has recovered from laboratory confirmed COVID-19 in the previous 3 months and has not been placed on quarantine. Note: Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2 dose vaccine series, or 2 weeks or more after receipt of one dose of a single-dose vaccine.

3. Are you currently experiencing or have you recently, (within the past 10 days) experienced ANY COVID-19 symptoms?

***Note:*** *Symptoms may occur with pre-existing medical conditions, such as allergies or migraines. You should only answer "Yes" if your symptoms are new or worsening.*

* Cough
* Shortness of breath
* Trouble breathing
* Fever (equal to or above 100.4 degrees Fahrenheit)
* Chills
* Muscle pain or body aches
* Headache
* Sore throat
* Loss of taste or smell
* Fatigue
* Congestion or runny nose
* Nausea or vomiting
* Diarrhea

4. Have you tested positive for COVID-19 through a diagnostic test within the past 10 days?

5. Have you traveled within the past 10 days and not complied with requirements of the New York State Travel Advisory?

**Attestation:** I agree that I will self-monitor these symptoms each day, report the outcome to the child care program, and not enter any child care program if any of the above symptoms or conditions are present.

|  |  |  |
| --- | --- | --- |
| X |  |       /       /       |
| Signature  |  | Date |
| X |  |       /       /       |
| Signature |  | Date |

***Note:*** *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*