

SOUTH SHORE COUNTRY DAY SCHOOL & CAMP

1149 Newbridge Road North Bellmore NY 11710 516-785-3311 516-785-3309 (FAX)

MEDICAL FORM

NAME _____ BIRTH DATE _____ EXAM DATE _____

HOME PHONE _____ MOM CELL# _____ DAD CELL # _____

EMERGENCY NAME _____ PHONE _____

Immunizations

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Health Specifics

Comments

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate Yes No

Signature of Examiner _____ Address _____

Please Print Name _____ City, State, Zip _____

Title _____ Phone _____ Date _____