



DIRECTORS
Minna & Fred Moskowitz

WINTER ADDRESS

Camp Westmont
2116 Merrick Ave.
Suite 3005
Merrick, NY 11566

Phone: (516) 771-3660
(516) 771-3661
Fax: (516) 771-2654



Wayne County
Poyntelle, PA 18454
Phone 570-448-2500
Fax 570-448-2063

STAFF HEALTH MEDICAL

RETURN BY: JUNE 1ST

THIS SIDE FILLED OUT BY PARENT OR GURADIAN AND CHECKED WITH PHYSICIAN AT TIME OF EXAMINATION

Name _____ Birth Date _____ Sex _____ Age _____
(last) (first) (initial)

Parent or Guardian (or Spouse) _____ Phone () _____

Home Address _____ City _____ State _____ Zip _____
Street & Number

If not available in an emergency notify: _____ Phone () _____

1. Name _____

Street & Number _____ City _____ State _____ Zip _____ Phone () _____

or 2. Name _____

Street & Number _____ City _____ State _____ Zip _____

HEALTH HISTORY: (Check - giving approximate dates)

- | | | |
|-----------------------------|---------------------------|----------------------|
| Ear Infections _____ | Allergies _____ | Diseases _____ |
| Rheumatic fever _____ | Hay Fever _____ | Chicken Pox _____ |
| Convulsions _____ | Ivy Poisoning, etc. _____ | Measles _____ |
| Diabetes _____ | Insect Stings _____ | German Measles _____ |
| Behavior _____ | Penicillin _____ | Mumps _____ |
| Lice Check _____ Date _____ | Other Drugs _____ | Asthma _____ |
| | Infectious Diseases _____ | Meas _____ |

Shot _____
Operations or Serious Injuries: (Dates) _____
Chronic or Recurring Illness _____
Other Diseases or Details of Above: _____
Any Specific activities to be restricted? _____

Important: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance
Insurance Company: _____ Policy Number: _____ Insured's S.S. # - _____
Camper wears: Glasses _____ Contacts _____ Braces _____ (parent)
Name & Phone Number of: Eye Doctor _____ Orthodontist _____

Parents Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. I hereby give permission to the medical personal selected by the camp director to administer medications, order routine tests and x-rays or to hospitalize, secure proper treatment for and to order injuction anaesthesia or surgery for my child as named above.

Parent or Guardian Signature - _____ Date _____

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of basic immunizations and most recent booster doses.

DPT Series _____	Booster _____	Tetanus Booster _____
Polio OPV (Sabin) _____	Booster _____	Typhoid _____
Measles Vaccine (live) _____	Tuberculin Test _____	Mumps Vaccine _____
German Measles (Rubella) _____	Small Pox _____	Other _____

MEDICAL EXAMINATION - To be filled out by licensed physician.

This examination should be performed within six months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities:

Code: Satisfactory
 Not Satisfactory
 Not Examined

BLOOD TYPE _____

Height _____	Weight _____	Blood Pressure _____	Hgb. Test _____	Lice Check _____	Date _____
Eyes _____	Extremities _____	Posture (spine) _____	Skin _____		
Glasses _____	Nose _____	Throat _____	Ears _____		
Heart _____	Lungs _____	Abdomen _____			
Urinalysis _____	Hernia _____				
Allergies (specify) _____					

Teeth _____ (please have a dental Check-up) General Appraisal _____

****A COPY OF YOUR INSURANCE CARD AND PRESCRIPTION CARD (FRONT AND BACK) MUST ACCOMPANY THIS MEDICAL FORM.**

Recommendations and restrictions while in camp

Special Diet _____

Special Medicine (name it) _____ is parent sending it? Y N U Yes fill out the Administration of Medicines for Swimming, diving _____ Strenuous Activity _____

**Any medications being stopped for the summer? _____

Other _____

**Have you been under the care of a doctor this past year? _____

**Have you been on any long term medication this past year? Y N If yes, please name: _____

I have examined the person herein described and have reviewed his health history. It is my opinion that he is physically able to engage in camp activities, except as noted above.

_____ MD

Examing Physician

Telephone () _____

Date _____

Address _____

state zip