ROCKAWAY WATERFRONT ALLIANCE

HEALTH RECORD FOR YOUTH IN ROCKAWAY WATERFRONT ALLIANCE PROGRAMS

(This side is to be completed by Parent before presenting to Physician)

NAME OF PROGRAM: _____

_____ _____ _____/_____/_____ ○ FEMALE ○ MALE
YOUTH'S LAST NAME YOUTH'S FIRST NAME DATE OF BIRTH

_____ _____ _____
HOME ADDRESS CITY/STATE/ZIP CODE HOME TELEPHONE NUMBER

_____ _____
PARENT'S OR GUARDIAN'S NAME CONTACT TELEPHONE

_____ _____
FATHER'S PLACE OF EMPLOYMENT TELEPHONE

_____ _____
MOTHER'S PLACE OF EMPLOYMENT TELEPHONE

_____ _____
IN CASE OF EMERGENCY-NOTIFY TELEPHONE

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY, NOTIFY: (FAMILY PHYSICIAN)

1._____ _____
TELEPHONE

OR

2._____ _____
TELEPHONE

IMPORTANT: Please notify RWA Program Staff if Child was/is exposed to any communicable disease at anytime three weeks prior to RWA attendance.

○NO ○YES If YES, please give type of exposure: _____

HEALTH HISTORY (Check, giving approximate dates):

ASTHMA: _____ BEHAVIOR: _____ CONVULSION: _____ CHICKEN POX: _____

DIABETIC: _____ EAR INFECTION: _____ HAY FEVER: _____ INSECT STINGS: _____

IVY POISONING, ETC: _____ GERMAN MEASLES: _____ MEASLES: _____ MUMPS: _____

PAST ILLNESS: _____ CONTAGIOUS ILLNESS: _____

OTHER DRUGS: _____ PENICILLIN: _____ RHEUMATIC FEVER: _____

OPERATIONS OR SERIOUS INJURIES (DATES): _____

HOSPITALIZATION: _____

CHRONIC OR RECURRING ILLNESS: _____

OTHER DISEASES OR DETAILS OF ABOVE: _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

Permission for all program activities unless otherwise noted by physician:

_____

Suggestion from Parent(s) or Guardian: _____

SIGNIFICANT HEALTH HISTORY AND CURRENT CONDITIONS

PLEASE LIST:

Medication taken: _____

Appliance worn (Glasses, Hearing Aid, etc.): _____

Conditions that modify activity (seizures, asthma, heart condition, etc.): _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby give my consent/authority to RWA Staff to obtain the necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship: _____ Signature: _____ Telephone: _____ Date: _____

Please complete send completed forms to:
RWA, PO BOX 900645, Far Rockaway, NY 11690 or by email to: info@rwalliance.org

ROCKAWAY WATERFRONT ALLIANCE

(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 need of the aforementioned Youth in RWA programs.

IMMUNIZATION HISTORY *(This is a record of dates of basic immunization and most recent booster doses)*

DPT or DT or TD – DATE:_____ DATE:_____ DATE: _____DATE:_____DATE:_____
POLIO - DATE:_____ DATE:_____ DATE:_____DATE:_____DATE:_____
MEASLES- DATE:_____
MUMPS- DATE:_____
RUBELLA- DATE:_____

(PPD-MANTOUX)

Tuberculin Test given: _____(most recent) Result:_____ ☐ ☐
m m

MEDICAL EXAMNATION *(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 EXTREMETIES

_____ _____ _____ _____
HEART EARS HEARING FEET

_____ _____ _____ _____
LUNGS SKIN NOSE TEETH

_____ _____ _____
ABDOMEN HERNIA GENITALIA

ALLERGY (PLEASE SPECIFY):_____

EUROLOGICAL FINDINGS:_____

DESCRIBE ABNORMAL FINDINGS AND/OR HANDICAPPING CONDITIONS:_____

_____

HAS CHILD EVER RECEIVED PRODUCTS CONTAINING HORSE SERUM? ○ NO ○ YES If YES, Please explain.

_____

_____
SPECIAL DIET

_____
MEDICAL MEDICATION (GIVE NAME AND DOSAGE)

_____
PARENT/GUARDIAN SEEKING SPECIAL MEDIATION?

_____ _____ _____
SWIMMING DIVING STRENUOUS ACTIVITY

GENERAL APPRAISAL:

_____

_____

I HAVE EXAMINED THE INDIVIDUAL HEREIN DESCRIBED, REVIEWED HIS/HER HEALTH HISTORY AND IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN RWA PROGRAMS AND YOUTH ACTIVITIES, EXCEPT AS NOTED ABOVE.

_____M.D. _____
PHYSICIAN'S SIGNATURE DATE

_____ _____ _____
ADDRESS CITY/STATE ZIP CODE

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