Child Name:____Date:________________________________

This side must be completed by a Licensed Physician, Nurse Practitioner or Physician's Assistant

Health examination determines fitness to engage in YWCA indoor and outdoor activities and should have been completed within the last twelve months. An examination for some other purpose during that same time period will also be acceptable.
Please attach a copy.

Immunization History (Documentation using *MONTH* and *YEAR* is required by NYS Department of Health)

DPT	1st	2nd	3rd	Booster	Booster
Oral Polio/Sabin	1st	2nd	3rd	Booster	Booster
MMr	1st	2nd	3rd		
Hib (haemophilus)	1st	2nd	3rd		
Hepatitis B	1st	2nd	3rd		
Varicella					
Tetanus					

Health Examination (Code: S = Satisfactory: X = Not Satisfactory: NE = Not Examined)

Height ____________ Weight__________ B.P.____________ Eyes___________ Glasses__________ Extremeties________
Heart_____________ Ears____________ Nose___________ Throat_________ Teeth____________ Lungs____________
Abdomen__________ Hernia_________ Spine_____________ Posture_________ Urinalysis_________ Skin______________

Allergies (please specify)____
List all current special needs (allergies, OT, Speech, Counseling, PT)____

____

Recommendations or restrictions while attending the YWCA of Niagara

Swimming or Diving__________________________________ Trips away from the YWCA______________________________
Strenuous Activity___________________________________ Special Restrictions___________________________________

FOR SUNCREEN USE ONLY

Sunscreen Name	SPF	Route	Dosage	Indications & Schedule	Healthcare Provider Order
		topical	as needed	daily prior to sun exposure	Yes No

We strongly suggest child bring behavior modification medications to the YWCA of Niagara.

We believe it will increase the child's ability to have a successful experience.

I have examined the person herein described and have reviewed the health history given by the parent/guardian on the other side of this form. It is my opinion that the individual is physically able to engage in all school/camp activities except as noted differently

Signature of examining Practitioner____ Date________________
Name of examining Practitioner (please print)____
Address____
Phone (   ) _______________ Fax (   )__________________________

For Office Use Only

Any communicable disease within the last two weeks? _______ If yes, describe____

Medications collected____Med "Vacations"_____________________________________

Other____

Health Interviewer :____

____