Village of Freeville Summer Recreation Program
Camper Health Certificate

This information is generally on file with your child's doctor, they can fax it to us at: 607-844-4971

Camper Name ______________________ Grade Entering __________
Parent/Guardian Name ______________________ Date of Birth __________

Primary Care Doctor: ______________________ Phone: __________

Dentist: ______________________ Phone: __________

Hospital Choice: ______________________

Insurance Carrier ______________________ Policy # __________

Health History:

Growth and Development: (please explain if not normal)

Physical	normal	not normal	__________
Mental	normal	not normal	__________
Emotional	normal	not normal	__________
Language	normal	not normal	__________

Additional comments as necessary

Medical History: (please describe if yes)

Does this child have allergies?	No	Yes	__________
Does this child take medications daily?	No	Yes	__________
Does this child have a hearing problem?	No	Yes	__________
Does this child have a vision problem?	No	Yes	__________

Are there ANY conditions requiring special attention by the Freeville SRP Staff? No Yes (please describe)

____

Immunizations:

Please provide the dates of administration of the following:

DPT	____	____	____	____	____
DT	____	____	____	Tetanus B	____
TOPV	____	____	____	____	____
Measles	____	Mumps	____	Rubella	____
MMR	____	____	Other	____	
HIB	____	____	____	____	
Hepatitis B		____	____	____	

Tests:	**Date**	**Results**
Tine	____	____
HGB/HCT	____	____
Urine	____	____
Lead	____	____
Sickle Cell	____	____

HEIGHT ________ Blood Pressure ________ Vision (R)20/____ (L)20/____
WEIGHT ________ Pulse ________ Hearing R ____ db L ____ db Scoliosis ________

____ ______________
Parent/Guardian Signature Date: