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)

To be provided by a medical provider or school nurse. (A Health Department Requirement)

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: