



FRIENDS ACADEMY SUMMER CAMPS

DUCK POND ROAD, LOCUST VALLEY, NY 11560

TEL: (516) 393-4207 FAX: (516) 465-1720



Please Print

STAFF MEDICAL HISTORY

(Required by the DOH)

Name: _____ Date of Birth _____

Address: _____

Phone: _____

Current Physician: _____ Tel No: _____

Emergency Contact - Name and Phone Number (other than home phone) _____

Place a "Y" next to each affirmative answer. Return Form by May 1st, 2005 to camp office.

Cardiovascular Disorders ___ Diabetes ___ T.B. ___ Hepatitis ___ Fainting ___ Epilepsy ___ G.I. Ulcer ___

Asthma ___ Kidney Disease ___ Rheumatic Fever ___ Chicken Pox ___ Allergies ___ Lyme Disease ___

Hearing/Visual Disorders ___ Other Communicable Disease ___ Major Illness ___

If you answered Yes to any of the above, please explain in more detail: _____

IMMUNIZATION RECORD:

DPT or DT _____ Measles, Mumps & Rubella _____ Latest Tetanus _____ Polio _____

TB Tine Test _____ Hepatitis B Vaccine _____ 1. _____ 2. _____ 3. _____

Medications Taken Regularly: _____

Allergies to Medications: _____

Have you been hospitalized in the past year? _____ If yes, please explain:

Are you under the Care of a physician now? _____ If yes, please explain:

Do you have any physical limitations? _____ If yes, please explain:

Other Pertinent Information:

Name: _____

Print

Signature

Date: _____

Parent's Signature (if under 18) _____