

Grenville Baker Boys & Girls Club

135 Forest Avenue ♦ Locust Valley, NY 11560 ♦ (516) 676-1460 ♦ Fax (516) 671-4681 ♦ www.gbbgc.org

Date _____

Health Record of _____ Birth Date ____ / ____ / ____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Grade Completed as of June 2009 _____

Health History (fill in year of occurrence and check appropriate categories):

Allergies	Drugs List each one	Tendency to:
Asthma _____	_____	Bed Wetting _____
Eczema _____	_____	Fainting _____
Hay Fever _____	_____	Hives _____
Poison Ivy _____	_____	Other _____
Insect Stings _____	_____	Disease Year
		Chicken Pox _____
		Epilepsy _____

Operations or Serious Injuries (dates): _____

Chronic or Recurring Illness: _____

Tendency or Susceptibility to: _____

Emotional or Physical Disabilities: _____

Comments of Suggestions from Parents: _____

Important: Please notify Grenville Baker Boys & Girls Club if this child has been exposed to any communicable disease, or if he/she has had a bad recent injury that the Club should know about.

Parent Authorization: This health history is correct as far as I know, and the person herein described has my permission to engage in all prescribed Club activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Club to hospitalize, secure proper treatment for, and to order injection, sedation, anesthesia, X-ray, or surgery for my child as named above.

(Parent/Guardian Signature)

(Date)

If I (parent/guardian) am not available in case of an emergency, please notify:

Name _____

Phone _____

Health Record of: _____

Medical Examination: *This section is to be filled out by physician only.*

Immunization History (dates of most recent immunizations):

DTP _____ DT _____ Polio Booster _____ IIIB _____ Hepatitis B _____ Varicella (chicken pox) _____		MMR _____ Tetanus Booster _____ Varavax Hepatitis _____ Haemophilus Influenza Type B _____
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Eyes _____	Height _____	Weight _____	Blood Pressure _____
Glasses _____			Pulse _____
Ears _____	Overweight _____	Underweight _____	Normal _____
Nose _____		Extremities _____	
Throat _____		Posture (Spine) _____	
Heart _____		Skin _____	
Lungs _____		Physical Disabilities _____	
Abdomen _____			
Hernia _____		Emotional Disabilities _____	
Teeth _____			

Allergies (specify) _____

Has this person menstruated? _____ If not, has she been informed about it? _____

If so, is her menstrual history normal? _____ Special considerations? _____

General Appraisal: _____

Recommendations for Club or Camp Activities:

Special Diet _____

Special Medicine (name) _____ Dosage _____

Is parent sending it? _____ With RX _____

Other comments or suggestions _____

I have examined the person herein described and I have reviewed his/her health history. It is my opinion that he/she is physically able to engage in Club or Camp activities, except as noted above.

Name _____ Signature _____
 Date _____ *(Examining Physician)*
 Address _____ Phone _____

Please Affix Doctor Stamp Here.