



**THIS SIDE TO BE COMPLETED
BY EXAMINING PHYSICIAN**

Vaccines	Dates of Basic Immunization	Booster
DPT-DT-Tetanus		
MMR		
Polio		
Hepatitis A		
Hepatitis B		
HIB		
Varicella		

I have examined the above named applicant on: _____
Note that the examination must have been within the last year.

- Patient's Blood Pressure: _____ Patient's Heart Rate: _____
- Patient's Height: _____ Patient's Weight: _____
- Patient had the following allergies: _____
- Medication and/or treatment to be continued at camp: _____
- In my professional opinion his/her condition does ___ / does not ___ preclude participation in an active camp program.
- Patient was found to be in good health with the following exceptions: _____

Physician's Signature: _____ Date: _____
No stamps will be accepted.
 Physician's Name: _____
 Telephone #: _____

NAME _____
 PROGRAM _____

Please indicate which medications are acceptable for administration to this applicant:

Name of Medication	Accepted	Not Accepted	Dosage	Alternative Medication
Acetaminophen (Tylenol)				
Antibiotic Ointment				
Anti-Diarrheal				
Anti-Fungal Cream				
Benadryl				
Claritin				
Cortisone Ointment				
Cough Syrup-DM				
Dramamine				
Gas-X				
Ibuprofen (Advil)				
Milk of Magnesia				
Pepto-Bismol				
Senna-Lax				
Sudafed				
Tums				
Tylenol Cold				
Tylenol Sinus				
Vasocon-A				
Visine				
Other:				
Other:				
Other:				
Other:				



THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

Confidential Medical Form

NCSY Summer Programs ~ 11 Broadway ~ 14th Floor ~ New York, NY 10004

Please return this original medical form. **FAXED COPIES WILL NOT BE ACCEPTED**

NAME OF PROGRAM:

DUE MARCH 15th

Name _____ Date of Birth ____ / ____ / ____ Age ____ SS# _____

Parent/Guardian: _____ Address _____ City _____ State _____ Zip _____

Telephone # _____ Cell Phone # (____) _____ Summer Address & Phone # _____

Business Telephone # (____) _____ Emergency Contact Person & Phone # _____ Relation _____

Check if child has or has had the following conditions

- Clotting Disorder
- Food Allergy
- Heart Condition
- Epilepsy
- Allergic to Medication
- Serious Injury
- Eating Disorder
- Behavioral Issues
- Disability
- Asthma
- Recurring Illness
- Diabetes
- Seizure
- Bee Sting Allergy
- Chicken Pox

Other Conditions: _____

Please indicate history of above and medication and/or treatment to be continued at camp _____

Would you like us to be aware of anything specific to assist us is the care of your child: (i.e. frequent colds, ear infections, stomach problems, insect bites, homesickness, and anxiety.)? _____

Please check if you have anything confidential that you would like to discuss with the nurse prior to your child's arrival at camp. _____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

Authorization of consent to Treatment of minor temporarily separated from his/her parents

I the undersigned, parent(s) of _____, a minor, do hereby authorize NCSY Summer Programs as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician and surgeon at a Hospital or Doctor's office. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital / Private Doctors which the physician exercises his/her best judgement may deem advisable. The authorization shall remain effective, unless revoked in writing and delivered to said agents(s).

Parent Signature _____ Date _____

Please paste a copy of your insurance card in the designated box below:

FRONT OF CARD

BACK OF CARD

OTHER SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN