BIBLE CAMP
40 Frost Mill Road, Mill Neck, NY 11765
Phone: (516) 922-4100 Fax: (516) 922-4172

HEALTH CERTIFICATE/APPRAISAL FORM

Name: _____

Gender: ☐ Male ☐ Female Grade: _____ Date of Birth: ____ / ____ / ____
month *day* *year*

IMMUNIZATIONS HEALTH HISTORY

☐ Immunization record attached
☐ No Immunizations given today
☐ Immunizations given since last Health Appraisal
_____

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral: ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

_____

✻ Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____ _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____ Date of Exam: _____

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile)	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

_____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

OPTIONAL INFORMATION, If known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ Free from contagions & physically qualified for all physical education, sports, playground, work & school activities **OR** only as checked:
_____ Limited contact: cheerleading, gymnastics, volleyball, cross-country, baseball, floor hockey, softball.
_____ Non-contact: badminton, bowling, golf, table tennis, archery, weight-train, dance, track, run, walk, jump rope.
☐ Specify medical accommodations needed for school: _____ ☐ None
☐ Known or suspected disability: _____ ☐ Please monitor
☐ Restrictions: _____ ☐ Please monitor
☐ Protective equiment required: ☐ Athletic Cup ☐ Sports goggles/impact resistant eyewear ☐ Other: _____

Provider's Signature: _____ Phone: _____
Provider's Name: _____ Fax: _____
Provider's Address: _____ (STAMP BELOW)
(Street Address) *(City, State)* *(ZIP Code)*

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IMMUNIZATION RECORD

Name: _____ D.O.B: _____

PLEASE CIRCLE TYPE OF VACCINE

	DATE		DATE		DATE		DATE
DTap/DTP		TOPV IPV		MMR#1		HIB	
DTap/DTP		TOPV, IPV		MMR#2		HIB	
DTap/DTP		TOPV, IPV		MEASLES #1		HIB	
DTap/DTP		TOPV, IPV		MEASLES #2		HIB	
DTap (Adacel)		TOPV, IPV		MUMPS			
				RUBELLA			

	DATE		DATE
HEPATITIS B		*TB Test (PPD)	
HEPATITIS B		(RESULT)	mm
HEPATITIS B		*Required during admitting year/Triennial Year	
PCV		VARIVAX	
		MenACWY	

OTHER

Vaccine	Dates