Grenville Baker Boys & Girls Club

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

Today's Date: _____

Health Record of _____ **Birth Date** ____/____/____

Home Address _____

Town _____ **State** _____ **Zip** _____

Phone _____ **Grade Completed as of June 2014** _____

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

Allergies		Drugs		**Tendency to:**	
Asthma		List each one		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 _____

Address _____ Town _____ Zip _____

Health Record of: _____

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 _____

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

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 _____ Doctor Signature _____

(Examining Physician)

Date Of Exam _____

Address _____ Phone _____

Please Affix Stamp Here.