

2019 PROGRAM MEDICAL FORM

This form is valid within the 2019 calendar year.

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Parent/Guardian Name _____ Phone (Daytime) _____ Home _____

OR

Parent Guardian Name _____ Phone (Daytime) _____ Home _____

If not available in an emergency, please notify:

Name/Relationship _____ Emergency Telephone _____

IMPORTANT: Please notify the office at Baltimore Woods if your child is exposed to any communicable disease during the two weeks prior to program attendance.

PARENTS AUTHORIZATION:

This health history is correct so far as I know, and the person herein described has permission to engage in all activities at Baltimore Woods except those noted below.

In the event I cannot be reached in an emergency at the above numbers, I hereby give permission to the physician selected by the BW Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

Signature _____ Date _____

NOTE: It is very important that the following information is ACCURATE and updated.

HEALTH HISTORY: (Check and/or give approximate dates)

Ear Infection _____	ALLERGIES:	DISEASES:
Rheumatic Fever _____	Hay Fever _____	Chicken Pox _____
Convulsions _____	Ivy Poisonings _____	Measles _____
Diabetes _____	Bee Stings _____	German Measles _____
Behavior _____	Penicillin _____	Mumps _____
	Other Drugs _____	Asthma _____

Operations or Serious Injuries (Dates) _____

Chronic or Recurring Illness _____

Other Diseases or Details of Above _____

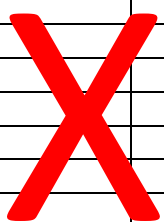
Any Specific Activities to be Encouraged _____

Restricted _____

Physician's Name and Telephone Number _____

IMMUNIZATON HISTORY: Please give month and year when immunized or the disease was contracted. Parent or guardian must fill in the dates below, or attach immunization records to this form. Your doctor can fax records directly to BWNC at 673-3671. NYS Liability Coverage does not allow BWNC to contact the doctor directly for this information.

	1 st	2 nd	3 rd	4 th	5 th
DTap					
dT/Tap					
OPV/IPV/eIP					
MMR					
Hepatitis B					
Varicella					
Hib					
Pneumococcal					
Other					



Note: This BWNC Summer Camp Program is licensed, as required by the NYS Dept. of Health. The program will be inspected twice this summer and inspection reports will be on file at :Onondaga County Health Dept. 421 Montgomery St, 12th FL, Syracuse, NY 13202

HAVE YOUR DOCTOR FAX VACCINATION RECORDS DIRECTLY TO (315) 673-3671