

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	Sickle Cell Screen:	Positive	Negative	Not done	Date: _____
No Immunizations given today	PPD:	Positive	Negative	Not done	Date: _____
Immunizations given since last Health Appraisal	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 5 th 5 th through 49 th 50 th through 84 th	Vision - Near Point	R	L	
85 th through 94 th 95 th through 98 th 99 th 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 equipment 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
_____	_____
_____	_____
_____	_____
_____	_____