LuHi Summer Programs
2021

131 Brookville Road
Brookville, NY 11545-3399

Certificate of Health

TO BE COMPLETED BY PARENT:

Name: _____ Birthdate: _____ Sex: _____ Age: _____

Home Address: _____ Home Phone: _____

Parent/Guardian: _____ Work/Cell Phone: _____

Parent/Guardian: _____ Work/Cell Phone: _____

Program(s) and Session(s) Attending

(please indicate program below):

Session 1: _____

Session 2: _____

Session 3: _____

Session 4: _____

Week(s) Attending (for campers enrolled in LuHi Country Day)

(please check weeks that apply below):

Week 1: ☐ Week 5: ☐

Week 2: ☐ Week 6: ☐

Week 3: ☐ Week 7: ☐

Week 4: ☐ Week 8: ☐

EMERGENCY CONTACT:

If Parent or Guardian is not available in the case of an emergency, please notify:

1. _____

(Name) (Address) (Phone)

2. _____

(Name) (Address) (Phone)

HEALTH HISTORY:
Please list any pertinent information regarding child's health history: (i.e., surgery, allergies, chronic illness, etc.)

_____

_____

_____

_____

***PLEASE NOTE:** If your child requires medication, please call for our **ADMINISTRATION OF MEDICATION** form at 516-626-1100 or print one from our webpage www.Luhisummercamps.org.

BE SURE TO COMPLETE OTHER SIDE!

_____
PARENT/GUARDIAN'S SIGNATURE

TO BE FILLED OUT BY A LICENSED PHYSICAN:

MEDICAL EXAMINATION:

This examination should be performed WITHIN 12 MONTHS of arrival at LuHi. An examination for some other purppose within this period is acceptable so long as it can determine fi tness to engage in strenuous activities.

_____ was examined by me on _____
(Child's Name)

and was found to be in good general health and able to participate in all athletic programs.

Positive Physical Findings: _____

Recommendations and/or Exceptions: _____

IMMUNIZATIONS:

D.P.T. _____

_____

_____

_____

DPT. BOOSTER _____

D.P.T. BOOSTER _____

SABIN ORAL VACCINE _____

_____

_____

_____

_____

MEASLES VACCINE _____

RUBELLA VACCINE _____

MUMPS VACCINE _____

HAEMOPHILUS INFLUENZA B _____

HEPATITIS B _____

VARICELLA _____

HEIGHT: _____

WEIGHT: _____

BLOOD PRESSURE: _____

SCOLIOSIS SCREEN: _____

VISION SCREEN: _____

URINE: _____

SIGNATURE: _____ **M.D.**

DATE: _____

_____

TELEPHONE: _____ **ADDRESS:** _____