WHITE PLAINS YOUTH BUREAU
After School/Summer Camp
Child Medical Examination Form

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Physical must be current within 12 months of program start in September. Examination for some other reason within this period is acceptable, and may be documented on a different health form. The purpose of the examination is to determine fitness to engage in after school program activities.

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Physical Examination

Please use: Satisfactory = S, Not Satisfactory = N (Explain), Not Examined = 0

Height _________ Weight ________ Blood Pressure ________ Hbb Test_______

Urinalysis _______ Eyes ____ (Glasses), Extremities ______ (Posture) _________

Spine _______ Skin __________ Ears ________ Nose _______ Throat ________

Teeth ______ Heart ______ Lungs ________ Abdomen ______ Hernia ________

ADDITIONAL INFORMATION ON REVERSE SIDE ➔

Child Medical Examination Form (continued)

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Recommendations or restriction for participation:

Physician's Statement

I have examined the child named here and reviewed the medical history. It is my opinion that this child is physically able to engage in normal after school activities, except noted above. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

(   )
Phone

Date