鳴遠青少年兒童夏令營 學生健康檢查表

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician 請家長填妥此表後交醫生填寫背面**)**

NAME OF PROGRAM: **MING YUAN SUMMER DAY CAMP**

_____ _____ _____/_____/_____ M 男 □ F 女 □

CHILD'S LAST NAME 學生英文姓 | FIRST NAME 學生英文名 | BIRTH DATE 出生日期 | SEX 性別

Home Address 家庭住址: _____ Phone 電話: _____

Parent or Guardian 父母或監護人: _____ Phone 電話: _____

Place of Employment 工作地方

Father (Guardian)父親/監護人: _____ Phone 電話: _____

Mother (Guardian)母親/監護人: _____ Phone 電話: _____

In case of emergency, notify 緊急情況通知人: _____ Phone 電話: _____

If Parent, Guardian are not available in an emergency, notify:遇到緊急情況，如無法聯絡到父母及監護人， 應當通知:

1. _____ Phone 電話: _____

or 或 2. _____ Phone 電話: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
該學生於參加此夏令營前三週內是否有爆發傳染病: Yes 有 □ No 無 □

(If Yes, state type of exposure 如果有，請列出種類: _____)

HEALTH HISTORY: (Check box if child has had afflictions, giving approximate dates)（如以下疾病有影響小孩請指出 "V"，並列出大概日期）

□ Rheumatic Fever 關節炎_____
□ Seizures 羊顛瘋 _____
□ Diabetes 糖尿病_____
□ Asthma 哮喘_____
□ Chicken Pox 水痘 _____

Allergies（過敏）

□ Hay Fever 花粉症_____
□ Poison Ivy, etc. 籐毒_____
□ Insect Stings 蚊叮蟲咬_____
□ Penicillin 青霉素_____
□ Other Drugs 其他藥物_____
□ Food 食物_____

Other Past Illnesses 其它以往疾病 _____

Operations or Serious Injuries (Dates)手術或嚴重受傷日期 _____

Hospitalization (Dates)住醫院日期 _____

Chronic or Recurring Illness 慢性或再發性疾病 _____

Any specific activities to be encouraged 應鼓勵的活動？ _____

Conditions that require activity to be restricted 因健康情形應禁止的活動？ _____

Permission for all program activities unless otherwise noted by Dr. 容許參加所有活動，除非有醫生: _____指示

Appliance worn (glasses, contacts, etc.)所佩戴醫療設備（眼鏡，隱型眼鏡等） _____

Medication Taken 目前所用藥物_____

Suggestion from Parent/Guardian 父母親/監護人建議: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT& PICTURE RELEASE

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Permission is hereby granted for photographs to be taken of my child during Ming Yuan School and Day Camp activities, and Ming Yuan has the right to utilize these photographs in its brochures or display materials.

Relationship_____ Signature_____ Date_____ Tel. #_____

與學生關係 | 簽名 | 日期 | 電話號碼

PHYSICAL EXAMINATION

(To be filled out by Physician-please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY-This is a record of dates of basic immunization and most recent booster doses.

DTap, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzae type b (Hib)		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other	Date _____	Date _____	Date _____	Date _____	Date _____

MEDICAL EXAMINATION - To be filed out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S=Satisfactory
X=Not Satisfactory (Explain)
0=Not Examined

General Appearance _____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat-Tonsils _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____ Lungs _____ Skin _____

Hgb. Test (Date) _____Urinalysis (Date)_____

Eyes_____ Vision_____ w/Glasses_____ Extremities_____ Heart_____

Ears_____ Hearing_____

Neurological Findings_____

Describe Abnormal Findings and/or Handicapping Conditions_____

_____

Allergy: (*Please specify*)_____

Recommendations and restrictions while in camp:

Special Diet_____

Special Medicine (dose, route of administration, when should it be administered)_____

Is parent/guardian sending special medicine? _____

Activity Restrictions_____

Swimming_____ Diving_____

General Appraisal: _____

_____

_____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

_____M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____Address_____

Date of Examination_____ _____
ZIPCODE