Medical Form
(To be completed by Physician)

Student's Name _____

Address_____

Date of Birth (mo/day/yr)_____ M / F (Please circle one)

Please indicate the childhood illnesses the student has had and complete the information about student's current physical condition. If the student has not had that illness or condition, please check the "NO" box.

CHILDHOOD ILLNESSES	Yes	No	Date	CURRENT PHYSICAL CONDITIONS	Yes	No
Chicken Pox				Asthma		
German Measles				Bleeding/Clotting Disorder		
Measles				Cancer		
Mumps				Convulsions/Seizures		
Shingles				Diabetes		
				Frequent Ear Infections		
ALLERGIES				Heart Defect/Disease		
Hay Fever				High Blood Pressure		
Insect Sting Reaction				Kidney Disease		
Penicillin				Lung Disease		
Poison Ivy, Poison Oak, etc.				Vision Impairment		

IMMUNIZATION HISTORY

The New York State Department of Health requires a complete immunization history for each student enrolled in the TechBoyz program. This information must be completed by the student's physician or nurse practitioner. We also ask that the TechBoyz Program Coordinatorbe notified if the student has been exposed to any communicable diseases in the three weeks prior to the start of the program.

The student cannot be enrolled until we have this information on file.

DPT (Diphteria, Pertussis & Tetanus) List dates received	1st	2nd	3rd	Booster	Booster
Polio (Oral) List dates received	1st	2nd	3rd	Booster	Booster
MMR (Measles, Mumps, Rubella) List dates received	1st	2nd			
Varicella (chicken pox) List dates received	1st	2nd	3rd	Booster	Booster
HB (Hepatitis B) List dates received	1st	2nd	3rd		

I verify that all immunizations are current for the above named student.

Name of Doctor or Nurse Practitioner: _____

Doctor's Address: _____

Doctor's Phone Number: _____

Doctor's Signature: _____ **Date:** _____

(REQUIRED)

6–Day Medication Record

Name: _____ Date of Birth: (mo/day/year)_____

IT IS TECHBOYZ PROGRAM POLICY THAT, AT CHECK IN, ALL MEDICATIONS MUST BE GIVEN TO TECHBOYZ HEALTH STAFF TO BE KEPT IN A SECURE PLACE MONITORED BY EYF HEALTH STAFF OR TEAM LEADERS.

MEDICATION NAME	MEDICAL CONDITION	DOSE	START DATE	END DATE	TIME (am/pm) or with Meal

** If you need more space, please attach additional page. This form is confidential and will be shredded by August 15, 2019. **

***** All medications must be in their original vial which outlines the prescription and ***** the doctor's contact information.

OVER-THE-COUNTER MEDICATIONS ARE NOT AVAILABLE AT CAMP.

Any over-the-counter medications must be prescribed by the doctor with the camper's full name, date of birth and a valid expiration date not to expire before the start of camp and in the original container. Examples of over-the-counter medications include, but are not limited to, Tylenol, Advil, Benadryl, Midol and Tums.

Parent/Guardian name: (please print) _____

Parent/Guardian signature:_____Date: _____

Doctor's signature: _____ Date: _____
(REQUIRED)