

TRINITY DAY CAMP
139 West 91st Street
New York, NY 10024

STAFF MEDICAL FORM

NAME: _____ AGE: _____ SEX: _____

DATE OF BIRTH: _____

ADDRESS: _____

(street and apartment)

(City, State, Zip)

PHONE: Home _____ Business _____

PERSON TO NOTIFY IN CASE OF ILLNESS _____

ADDRESS: _____

PHONE: Home _____ Business _____

PERSONAL PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

PAST MEDICAL HISTORY: Do you have a history of any of the following? CIRCLE IF YES.

1. ASTHMA

3. EPILEPSY

5. HYPERTENSION

2. DIABETES

4. HEART DISEASE

6. TUBERCULOSIS

OTHER PROBLEMS: _____

PHYSICAL EXAMINATION FINDINGS:

Height _____ Weight _____

Blood Pressure _____

Tuberculin Skin Test: PPD Mantoux (5TU)

Date Tested: _____

Date Interpreted: _____

Result: _____

Chest X-ray (if required):

Date _____ Result _____

ALLERGIES: _____

MEDICATIONS you are taking: _____

PHYSICIAN'S SIGNATURE: _____

License No. _____ Date of Exam: _____

Agency Stamp: