

SCOPE SUMMER RECREATION PROGRAM  
AT WEST HEMPSTEAD  
MEDICAL FORM- 2010

\_\_\_\_\_  
Student's Last Name

\_\_\_\_\_  
First

\_\_\_\_\_  
Address

\_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Grade & School in September

\_\_\_\_\_  
*TWO Emergency Contacts & Phone #'s*

# Health History

Please have physician attach the most recent immunization records to this form.  
A physical is not required for this form, as long as your child has had a physical in the past year. Most doctors offices allow you to drop this form off to be filled out. **THIS FORM MUST BE RETURNED BY JUNE 4, 2010 to insure your child's registration status. Unless a registration form, health form, and payment are received by June 4, 2010 your child will be placed on a waiting list.**

Date of last physical examination \_\_\_\_\_

Are the student's immunizations up to date? \_\_\_\_\_

History of diabetes or TBC in the Family \_\_\_\_\_

Is the child physically able to participate in all school physical activities Yes \_\_\_\_\_ No \_\_\_\_\_

Are there any problems relating to growth and development \_\_\_\_\_

Has student any injury, disability or allergy? (specify) \_\_\_\_\_

\_\_\_\_\_  
Does this student take medication on a regular basis? \_\_\_\_\_

Remarks and recommendations, including immunizations given this past year (Please Print) \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
(Print) Physician's Name

\_\_\_\_\_  
Physician's Address & Phone #