SIDNEY ALBERT JCC
ALBANY JEWISH COMMUNITY CENTER

340 Whitehall Road ▪ Albany, NY 12208 ▪ (518) 438-6651▪ FAX (518) 459-0924

PHYSICIAN'S MEDICAL REPORT

NAME OF PERSON BEING EXAMINED	DATE OF BIRTH	DATE OF EXAMINATION

The above named child was examined and found to present no hazard from contagious and communicable disease and is in good general health.

	INCLUDE ALL DATES					
TB (Date)	DPT	1ST	2ND	3RD	BOOSTER	BOOSTER
HEP 'B'	ORAL POLIO	1ST	2ND	3RD	BOOSTER	BOOSTER
HAEMOPHILUS INFLUENZA 'B'	MEASLES	DATE	2ND	TUBERCULIN TEST (OPTIONAL)	TYPE	
	RUBELLA	DATE			RESULT	
VARICELLA	MUMPS	DATE	* Last tetanus shot (date): _____			

GIVE SPECIFICS FOR ALL YES RESPONSES AT RIGHT

YES	NO	1. Are there allergic problems?	
YES	NO	2. Are there allergies to drugs?	
YES	NO	3. Is medication regularly taken? (If yes, specify drug and condition)	
YES	NO	4. Are there any conditions requiring special attention from our camp staff?	
YES	NO	5. Is a special diet required? (If yes, specify diet and condition)	

6. TEETH (condition)

7. MENTAL GROWTH & DEVELOPMENT ☐ Normal ☐ Abnormal (If abnormal, describe)

7. PHYSICAL GROWTH ☐ Normal ☐ Abnormal (If abnormal, describe)

LIST ANY SPECIAL RECOMMENDATIONS CONCERNING CHILD'S HEALTH (use additional sheet of paper if necessary)

Physician's Signature	Address	Physician's Phone