2009 AT LAST! SUMMER PROGRAM MEDICAL FORM
Port Washington Union Free School District
Office of Educational and Community Services
Administrative Annex 90 Avenue C Port Washington, NY 11050
Phone: (516) 767-5470 Fax: (516) 767-5479
atlastinfo@portnet.k12.ny.us www.portnet.k12.ny.us

Instructions: Both sides of this form must be completed for all students.
Please mail or fax using the information above or bring to your parent orientation meeting.
Physician or health care provider's signature is required.
This form must be received by June 1, 2009.
Students who do not return this form cannot attend the program.

_____ _____
Student's Last Name First Name Address

_____ _____
School Grade in September, 2007

Health History

Date	Date	Date	Date
_____Chicken Pox	_____Poliomyelitis	_____Heart Disease	_____Frequent Headaches
_____Diphtheria	_____Rheumatic Fever	_____Tuberculosis	_____Frequent Colds
_____German Measles	_____Scarlet Fever	_____Contact w/TBC	_____Frequent Nosebleeds
_____Measles	_____Whooping Cough	_____Ear conditions	_____Frequent Sore Throat
_____Mumps	_____Diabetes	_____Operation	_____Tonsillectomy
_____Influenza B	_____Hepatitis B		

Asthma and/or Allergy _____ Specify: _____

Serious Injury_____

History of Diabetes or TBC in the family_____

Is this child able to participate in all physical activities? Yes ☐ No ☐

Are there any problems related to growth and development? _____

Has student any defect or disability? Specify: _____

Does this student take medication on a regular basis? Specify: _____

Remarks and recommendations, including immunizations given this past year (*please print*): _____

_____

_____ _____ _____
Physician's Signature Date Phone

Print Physician's Name _____

2009 AT LAST! SUMMER PROGRAM MEDICAL FORM

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Office of Continuing and Community Education
Administrative Annex 90 Avenue C Port Washington, NY 11050
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_____ _____
Student's Last Name First Name Address

_____ _____
Date of Birth School/Grade

DTAP ___/___/___ ___/___/___

DTP/HIB ___/___/___ ___/___/___ ___/___/___ ___/___/___

HEP B ___/___/___ ___/___/___ ___/___/___ ___/___/___

DTP ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___

DT ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___

TD ___/___/___ ___/___/___ ___/___/___

HIB ___/___/___ ___/___/___ ___/___/___ ___/___/___

OPV ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___

EIPV ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___

MMR ___/___/___ ___/___/___

ME___/___/___ **ME** ___/___/___ **MU** ___/___/___ **RU**___/___/___ **MR**___/___/___

VZV___/___/___ ___/___/___

_____ _____ _____
Physician's Signature Date Phone

Print Physician's Name _____