



**BOYS & GIRLS CLUB**  
SALAH M. HASSANEIN  
VARIETY BOYS & GIRLS CLUB OF QUEENS

Funded by NYC Dept. of Youth  
& Community Development  
Contract Nos.:42377,840103

**HEALTH RECORD** (this side to be filled in by parent before presentation to physician)

Name of Program: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
LAST FIRST

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Employment: Mother (Guardian) \_\_\_\_\_ Phone: \_\_\_\_\_  
Father (Guardian) \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Phone: \_\_\_\_\_

If Parent, Guardian are not available in an emergency, notify:

1: \_\_\_\_\_ Phone: \_\_\_\_\_

2: \_\_\_\_\_ Phone: \_\_\_\_\_

**IMPORTANT:** Has this child been exposed to any communicable disease during the three weeks prior to program start:

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, state type of exposure: \_\_\_\_\_

**HEALTH HISTORY:** (Check box if child has had afflictions, give appropriate dates)

**Allergies**

- Rheumatic Fever \_\_\_\_\_
- Asthma \_\_\_\_\_
- Hay Fever \_\_\_\_\_
- Penicillin \_\_\_\_\_
- Seizures \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Poison Ivy, etc. \_\_\_\_\_
- Other Drugs \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Insect Stings \_\_\_\_\_
- Foods \_\_\_\_\_

Other Past Illnesses \_\_\_\_\_

Operations or Serious Injuries (Dates) \_\_\_\_\_

Hospitalization (Dates) \_\_\_\_\_

Chronic or Recurring Illness \_\_\_\_\_

Any specific activities to be encouraged? \_\_\_\_\_

**Conditions that require activity to be restricted?** \_\_\_\_\_

Permission for all program activities unless otherwise noted by doctor? \_\_\_\_\_

**Appliance worn (glasses, contacts, etc.)** \_\_\_\_\_

**Medication taken** \_\_\_\_\_

Suggestion from Parent/Guardian? \_\_\_\_\_

**CONSENT FOR EMERGENCY TREATMENT** I do hereby give authority to the VBGCQ staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ Tel \_\_\_\_\_



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**PHYSICAL EXAMINATION** (to be filled out by physician-please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child.

**IMMUNIZATION HISTORY:** This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenza Type b (HIB)	Date _____	Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varicella	Date _____	Date _____			
Pneumococcal Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other _____	Date _____	Other _____	Date _____	Other _____	Date _____

**MEDICAL EXAMINATION:** To be filled out by licensed physician.  
Examination is acceptable when performed no more than  
12 months prior to start of program.

CODE: S = Satisfactory  
X = Not Satisfactory (Explain)  
O = Not Examined

General Appearance \_\_\_\_\_

Genitalia \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Posture & Spine \_\_\_\_\_ Throat-Tonsils \_\_\_\_\_

Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Feet \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_

Hgb. Test (Date) \_\_\_\_\_ Urinalysis \_\_\_\_\_

Eyes \_\_\_\_\_ Vision \_\_\_\_\_ w/Glasses \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_ Ears \_\_\_\_\_ Hearing \_\_\_\_\_

Neurological Findings \_\_\_\_\_

Describe Abnormal Findings and/or Handicapping Conditions \_\_\_\_\_

Allergy: (Please specify) \_\_\_\_\_

**RECOMMENDATIONS AND RESTRICTIONS:**

Special Diet \_\_\_\_\_

Special Medicine (dose, route of administration, when it should be administered) \_\_\_\_\_

Is parent/guardian sending special medicine \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

Swimming \_\_\_\_\_ Diving \_\_\_\_\_

General Appraisal \_\_\_\_\_

*I have examined the person herein described, reviewed his/her health history and it is my opinion the he/she is physically able to engage in VBGCQ activities, except as noted above.*

Examining Physician Signature \_\_\_\_\_ Physician's Name (print) \_\_\_\_\_

Tel \_\_\_\_\_ Address \_\_\_\_\_

Date of Examination \_\_\_\_\_