TOWN OF PLEASANT VALLEY
1554 Main Street
Pleasant Valley, NY 12569
Sandy Coe, Recreation Director
Phone: 845-266-9222
Fax: 845-266-3873
www.pvrec.com

SUMMER PROGRAM – Medical Screening

MM/DD/YR: _____/_____/_____

Please check one: CAMP SUNNY DAYS ☐ BASKETBALL CAMP ☐ SOCCER CAMP ☐

Session/s child/CIT will attend:_____
(Only applies to Camp Sunny Days)

NAME _____ DOB: _____Grade in Sept. _____

Parent/Guardian Name: _____
Please provide all applicable telephone numbers where you could be reached during the day:

Home: _____ Cell: _____ Work: _____

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY DURING CAMP HOURS:
Please provide us with CURRENT telephone numbers for TWO people to potentially be called if your child becomes injured or ill during camp. We do not have the facilities or the staff to care for a sick child. Please have someone available if you work during the day and be sure they're aware their contact info was listed here.

Name _____ Home # _____Cell #_____

Name _____ Home # _____Cell #_____

RECORD OF IMMUNIZATIONS: Dutchess County Health Department regulations require that we have the dates of these immunizations on file from Physician's record - please attach Physician's Record.

My child's Immunization records will be submitted (Please check one):

Along w/ this Medical Screening Form ☐ Via Fax From Dr's Office ☐ Via US Mail ☐ Rec Drop Box ☐

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Does your child have a vision, hearing or other physical disability which requires special attention or would limit participation in camp activities? **Y/N**
EXPLAIN:_____

2. Does your child require emergency treatment for epilepsy, diabetes, nose bleeds, bee stings, asthma, etc.? **Y/N**
EXPLAIN:_____

3. Does your child take any medication on a daily basis? **Y/N**
If so, please list: _____

4. Does your child have allergies? **Y/N**
EXPLAIN: _____

5. Is there any additional information that will help us get to know your child better? **Y/N**
EXPLAIN:_____

I authorize the P.V. Summer Program to provide emergency treatment of an injury to, or illness of my child, if qualified medical personnel consider treatment necessary and perform the treatment.
This authorization is granted, only if I can NOT be reached, and a reasonable effort has been made to do so.

Parent / Guardian _____ Date _____