



**TOWN OF PLEASANT VALLEY**

1554 MAIN STREET  
PLEASANT VALLEY, NY 12569  
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**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 \_\_\_\_\_