CEED
Center for Environmental Education & Discovery

Date Received:
Date Nurse Reviewed:

CEED SUMMER NATURE EXPERIENCE
2019 HEALTH FORM

THIS HEALTH FORM MUST BE COMPLETED, STAMPED AND SIGNED BY A PHYSICIAN FOR EACH CHILD PARTICIPATING IN THE PROGRAM AND SUBMITTED 2 WEEKS PRIOR TO THE START OF THE SESSION. NO CHILD WILL BE ALLOWED TO ATTEND THE CEED SUMMER NATURE EXPERIENCE WITHOUT THIS COMPLETED HEALTH FORM ON FILE. NO EXCEPTIONS CAN BE MADE. A $25.00 LATE PROCESSING FEE IS DUE IF THE HEALTH FORM IS SUBMITTED LESS THAN 7 DAYS BEFORE THE PROGRAM SESSION BEGINS.

Dear Doctor,
Your patient has enrolled in the CEED Summer Nature Experience in Brookhaven Hamlet. This summer program will engage your patient in outdoor nature study and exploration through several acres of trails and boardwalk, in forest and marsh settings. Activities may include handling wildlife such as bugs, reptiles, amphibians, mammals, **fish** and **shellfish**. Please complete and sign the form below and/or attach current exam and vaccination records. Please include any restrictions needed to keep your patient healthy and safe during their CEED Summer Nature Experience. Thank you!

Child's Name: ☐ M ☐ F	**DOB:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Polio
	☐ Diphtheria/DPT	☐ Chickenpox / Varicella
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any Allergies to:	
Medication Allergies (penicillin, etc.):	Reaction:
Insect Allergies (bee sting, etc.):	Reaction:
Inhalation Allergies (pollen, dust, etc.):	Reaction:
Contact Allergies (**shellfish**, **fish**, latex, etc.):	Reaction:
Food Allergies (peanuts, chocolate, etc.):	Reaction:

Medical Conditions and Health History:
Epilepsy, diabetes or asthma?
Any other patient medical conditions, communicable diseases, or other? (Attach records if needed):
Any restrictions on activity or exercise?
Any physical disabilities?
Does your child carry an epi-pen, inhaler, or other:

Are there any medications the patient will be taking during the program? (Medications are supplied by parent/guardian)

Name:	Dose/Time:	Reason:
Name:	Dose/Time:	Reason:
Name:	Dose/Time:	Reason:
Herbal/Non-Prescription:	Dose/Time:	Reason:

I believe this child is able to attend and participate in the CEED Summer Nature Experience:	☐ Yes	☐ No
I give permission for the staff/counselors to administer the above-listed medications as directed:	☐ Yes	☐ No

Physical Examination Date: _____ ☐ Check if Exam Records attached ☐ Check if Immunization Records attached

_____ _____ _____
Physician's Signature | Physician's Name – Please Print | Date

(Physician Stamp)

_____ _____
NYS License Number | Physician / Office Phone Number