CEED
CENTER FOR ENVIRONMENTAL EDUCATION AND DISCOVERY

Date Received:
Date Nurse Reviewed:

CEED SUMMER NATURE EXPERIENCE
2020 HEALTH FORM - updated 4/30/20

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. IN AN EFFORT TO BE FLEXIBLE DURING THESE DIFFICULT TIMES, WE ARE WAIVING THE $25 LATE PROCESSING FEE THAT NORMALLY APPLIES WHEN A HEALTH FORM IS LATE. IF YOU ARE DELAYED, PLEASE GET IN TOUCH WITH US AT 631-803-6780 OR INFO@CEEDLI.ORG.

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