NYFA NEW YORK FILM ACADEMY

Health Examination Form
Summer Camps 2026

TO BE COMPLETED BY PARENT/GUARDIAN AND/OR HEALTHCARE PROVIDER PLEASE PRINT CLEARLY

Child's Last Name | First Name | Middle Name

Sex ☐ Female ☐ Male ☐ Upspecified

Date of Birth *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address

Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code

Camp Name and Location

Phone Numbers
Home _____
Cell _____
Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** Last Name First Name
☐ **Foster Parent**

TO BE COMPLETED BY HEALTHCARE PROVIDER ***If "yes" to any item, please explain (attach addendum, if needed)***

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications ☐ None ☐ Yes *(list below)*

Dietary Restrictions ☐ None ☐ Yes *(list below)*

DEVELOPMENTAL ☐ Within normal limits

☐ Cognitive *(e.g., play skills)* _____
☐ Communication/Language _____
☐ Social/Emotional _____
☐ Adaptive/Self-Help _____
☐ Motor _____

IMMUNIZATIONS – DATES

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__
COVID-19	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *Specify:* _____ __/__/__ ; _____			__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions (*specify*) _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI) US only

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __

Date Reviewed: __/__/__

REVIEWER:

Please Email your completed form to the location specific email address below:

NEW YORK CITY: nyc2026@nyfa.edu
LOS ANGELES: la2026@nyfa.edu
FLORENCE: florence2026@nyfa.edu
PARIS: paris2026@nyfa.edu
HARVARD UNIVERISTY: harvard2026@nyfa.edu