

# MEDICAL FORM

**Instructions** \* Please be sure to complete the PARENT SECTION: *then* give this form to your physician.

*return before camp begins*  
Joel Ross Tennis/Golf Camp  
PO Box 62H Scarsdale, NY 10583  
after June 20: Kent School Kent, CT 06757

**PARENT SECTION:** *Though the likelihood of an emergency at camp is small, all information noted here must be provided. If details of your child's medical history are unclear, please have the physician assist you in completing both sides of this sheet. Authorizations must be signed to guarantee attendance at camp. Thank you.*

Camper/Staffer Name \_\_\_\_\_ Gender \_\_\_\_\_  
Birth date \_\_\_\_\_ Session(s) attending \_\_\_\_\_

Parent Name (s) \_\_\_\_\_  
Home ph \_\_\_\_\_ Work ph \_\_\_\_\_  
Cell ph \_\_\_\_\_ e-mail/fax \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If two household family...Parent Name \_\_\_\_\_  
Home ph \_\_\_\_\_ Work ph \_\_\_\_\_  
Cell ph \_\_\_\_\_ e-mail/fax \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact. If parent/guardian isn't available, please notify:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone #'s (work, home & cell) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of child's physician \_\_\_\_\_  
Phone \_\_\_\_\_  
*\*Please attach address/phone of all specialists caring for your child*

Do you carry family medical/hospital insurance? Yes \_\_\_ No \_\_\_  
If so, carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_  
Carrier address \_\_\_\_\_  
Name of insured (parent/guardian) \_\_\_\_\_

**Parent Authorizations** \* The health history below is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted...I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer hospitalization, injections, anaesthesia, surgery, and/or any other proper treatment for the person named above...This form may be copied for trips out of camp.

**PARENT SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

**Health History to be completed by Parent** \* *the intent of this information is to provide camp health care personnel and counselors the background to provide appropriate ongoing and emergency care. In completing this form it is assumed that the camp directors will be provided with any and all updated medical information right up to the first day of camp.*

**Medications** (including vitamins) taken routinely. \* *if additional meds, note on attached page.*

Medication #1 \_\_\_\_\_  
Dosage \_\_\_\_\_ How often each day \_\_\_\_\_  
Reasons for taking:

Medication #2 \_\_\_\_\_  
Dosage \_\_\_\_\_ How often each day \_\_\_\_\_  
Reasons for taking:

This person takes NO medications on a routine basis \_\_\_\_\_

**Allergies** \* *Please describe reaction and management of reaction. Use additional page if necessary.*

Allergies to medications, and reaction:

Allergies to food, and reaction:

Other allergies (insect stings, hay fever, asthma, animals, etc. )

**PARENT** \* Please see other side for more required information

# PARENT SECTION Continued...

Camper/Staffer Name \_\_\_\_\_

**Restrictions** \* Please discuss these in detail on an attached page.

Dietary:

Physical activity to be restricted:

**Contagious diseases**

	Date
___ Measles	_____
___ Chicken Pox	_____
___ German Measles	_____
___ Mumps	_____
___ Hepatitis	_____

**Additional Information** - about the participant's physical or mental health about which we should be aware - can be provided below or on an attached page.

<b>General Questions</b> i.e. 'you' refers to child	Yes	No
1. Have you ever been hospitalized?	___	___
2. Have you ever had surgery?	___	___
3. Have you any chronic or recurring illness/condition?	___	___
4. Have you had mononucleosis in the past 12 months?	___	___
5. Have you ever passed out during/after exercise?	___	___
6. Have you ever been dizzy during/after exercise?	___	___
7. Have you ever had chest pain during /after exercise?	___	___
8. Have you ever had high blood pressure?	___	___
9. Have you ever been told you have a heart murmur?	___	___
10. Have you ever had a head injury?	___	___
11. Have you ever been knocked unconscious?	___	___
12. Do you have frequent headaches?	___	___
13. Have you ever had seizures?	___	___
14. Do you have epilepsy?	___	___
15. Do you have diabetes?	___	___
16. If female, is menstrual history abnormal? ___	___	___
17. Have you had frequent ear infections?	___	___
18. Do you have any skin problems (rash, acne, etc.)?	___	___
19. Is there a history of bed wetting?	___	___
20. Is an orthodontic appliance being brought to camp?	___	___
21. Do you wear glasses, contacts or protective eye wear?	___	___

*\*If you answered yes to any of the above, please provide details on another page.*

**Attention Parent: Please attach copy of camper's health insurance card to this form.**

## PHYSICIAN SECTION

\* Please review the information on both sides of this page and complete the questions below. Use additional sheets as necessary.

1. I have reviewed this entire medical form and confirm that all information herein and on any attached pages is correct \_\_\_ should be clarified as follows:

2. The above person is \_\_\_ is not \_\_\_ able to participate in an active camping program.  
 3. The applicant is under the care of a physician for the following conditions:

Current treatment includes:

- 4. Recommendations and restrictions at camp:
- 5. Treatment to be continued at camp:
- 6. Medications to be administered at camp (see attached sheet):
- 7. Any medically prescribed meal plan or dietary restrictions:
- 8. Any allergies to be noted:

**Physical exam**

Date of last examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

**Immunization history:**

Vaccine	up to date	yes	no
Measles	___	___	___
Mumps	___	___	___
Rubella	___	___	___
Chickenpox	___	___	___
Tetanus	___	___	___
Hepatitis B	___	___	___
Diphtheria	___	___	___
Pertussis	___	___	___
Polio	___	___	___

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ Printed Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Form completed by \_\_\_\_\_ Date \_\_\_\_\_