



TENNIS • FITNESS • MULTISPORT

Phone: (845) 226-8733

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2009 SUMMER CAMP HEALTH EXAMINATION FORM

- This **MUST** be turned into Sport & Wellness **BEFORE** your child's first day of camp signed by a parent/guardian and dated.
- We must have a copy of your child's immunization records and a copy of the last physical exam (Both must be within the last calendar year of the session your child is signed up for) or fill out this form and have signed, stamped and dated by physician.

Name: _____

Birth Date: _____ Male/Female: _____ Age: _____

Parent/Guardian's Name: _____

Home Address: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Medicaid #: _____ Medical Plan/Insurance: _____ ID/Policy: _____

If Medical Plan/Insurance, full billing address: _____



IMMUNIZATION HISTORY: (This is a record of dates of basic immunization and recent boosters)

DTP or Di or Td or Dtap or Tdap: ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____

TB: ____/____/____

Polio; TOPV (Sabin) ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____

IPV (Salik) ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____

Measles: ____/____/____, ____/____/____

Mumps: ____/____/____, ____/____/____

Rubella: ____/____/____, ____/____/____

Varicella: ____/____/____, ____/____/____ MMR: ____/____/____, ____/____/____

HIB: ____/____/____, ____/____/____

HepatitisB: ____/____/____, ____/____/____, ____/____/____



HEALTH HISTORY: (check all that apply and include dates when necessary)

_____ Sickle Cell

_____ Bee Sting Allergies

_____ Chickenpox

_____ Rubella

_____ Insect Bites

_____ Measles

_____ Sinusitis

_____ Penicillin

_____ German Measles

_____ Scarlet Fever

_____ Constipation

_____ Mumps

_____ Stomach Aches

_____ Diarrhea

_____ Poliomyelitis

_____ Hepatitis

_____ Epilepsy

_____ Whooping Cough

_____ Hay Fever

_____ Rheumatic Fever

_____ Ear Infections

_____ Poison Ivy

_____ Diabetes

_____ Eye Infections

_____ Serious Ivy, Oak or Sumac Poisoning

_____ Operations or Serious Injuries

Does your child wear glasses? _____ Does your child have hearing difficulties? _____
If your child is a girl, has she begun to menstruate? _____ If not, does she know about the cycle? _____
Does your child have a chronic or reoccurring illness? If yes, please explain. _____

MEDICATIONS BEING TAKEN:

Is your child taking any prescribed medication regularly? _____

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire camp session(s). Keep it in the original package/bottle that identifies the prescribing physician (if a prescription drug). The name of the medication, the dosage, and the frequency of administration must be provided on a Doctor's prescription for our administration.

Medication #1: _____
Dosage: _____ Specific times taken each day: _____

Medication #2: _____
Dosage: _____ Specific times taken each day: _____

Medication #3: _____
Dosage: _____ Specific times taken each day: _____

Attach additional pages for more medications.

Identify any medications taken during the school year that child does/may not take during the summer:



Please explain any other conditions which may require special attention:

I certify that the medical history of the child on this form is correct, and that the person herein described has permission to engage in all activities, except the ones noted above.

Parent/Guardian Signature

Telephone

Date (*within last 3 months*)

Physicians Signature

Physicians Stamp:

Date _____