

Health History and Examination Form
This page is to be filled out by the
Parent of Guardian of minors
(Page 1 of 2)



Please Mail Form to:
New York Sports Academy
P.O. Box 237
Greenvale, New York 11548

Name _____ Birthdate _____ Sex _____ Age _____

Parent or Guardian _____

Home Address _____ Phone _____

Business Address _____ Phone _____

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____

Business Address _____ Phone _____

If Not available in an emergency, notify

Name _____

Address _____ Phone _____

Health History

(check, give approx dates)

_____ Frequent Ear Infections

_____ Heart Defect/Disease

_____ Convulsions

_____ Diabetes

_____ Bleeding/Clotting Disorders

_____ Hypertension

_____ Mononucleosis

Diseases

_____ Chicken Pox

_____ Measles

_____ German Measles

_____ Mumps

Allergies (dates not needed)

_____ Hay Fever

_____ Ivy Poisoning, etc.

_____ Insect Stings

_____ Penicillin

_____ Other Drugs

_____ Asthma

_____ Other (Specify)

Operations or serious injuries(dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions _____

Current medications (send with instructions) _____

Other diseases _____

Name of Dentist _____ Phone _____

Name of family physician _____

Phone _____

Do you carry family medical /hospital insurance?

_____yes _____no

If so, indicate Carrier _____

Policy or Group # _____

Suggestions on health related information for camp personnel

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary related transportation for 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 treatment, including hospitalization, for the person named above.

Signature of parent or guardian _____ **Date** _____

Name of Participant _____ Birthdate _____

Immunization History

<u>Vaccines</u>	<u>Year of Basic Immunization</u>	<u>Year of Last Booster</u>
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Diphtheria		
Pertussis (Whooping Cough)		
Tetanus		
or _____		
Tetanus		
Diphtheria		
or _____		
Tetanus _____		
Oral Polio (Sabin) TOPV _____		
Injectable Polio (Salk) _____		
Measles (hard measles, red measles, Rubeola) _____		
Mumps _____		
Rubella (German Measles, 3 day measles) _____		
Other _____		
Tuberculin test given _____ (most recent) _____		
Haemophilus influenza b (HIB) _____		
Hepatitis B _____		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past year. Date Examined _____ In my opinion, the above's condition _____ does _____ does not preclude his/her participation in an active camp program.

Height: _____ Weight: _____ Blood Pressure: _____

The applicant is under the care of a physician for the following condition(s) _____

Current Treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? _____ yes _____ no Does applicant have diabetes? _____ yes _____ no

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp ? _____

Any medication to be administered at camp? _____

Any medically prescribed meal plan or dietary restrictions? _____

Any Allergies (food, drugs, plants, insects., etc.) _____

Activities to be limited _____

Additional Health Information _____

Licensed Physician's Signature _____

Address _____ Phone _____

Date of Form Completion _____ *By _____

*(initial if completed by nurse or physician's assistant)