Joan & Alan Bernikow
Jewish Community Center
of Staten Island

SPORTS CAMP HEALTH RECORD

(This side to be filled in by parent before presentation to physician)

CAMP: ☐ **Basketball Camp** ☐ **Soccer Camp** ☐ **Aquatics Camp**

_____ _____ ___/___/_____ M ☐ F ☐

CHILD'S LAST NAME FIRST NAME BIRTHDATE SEX

Home Address: _____ Phone: _____

Parent or Guardian_____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2_____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:

Yes ☐ No ☐ (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

Allergies:

☐ Rheumatic Fever _____	☐ Hay Fever _____	☐ Food _____
☐ Seizures _____	☐ Poison Ivy, etc. _____	☐ Food _____
☐ Diabetes _____	☐ Insect Stings _____	☐ Food _____
☐ Asthma _____	☐ Penicillin _____	☐ Food _____
☐ Chicken Pox _____	☐ Other Drugs _____	☐ Food _____

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

We consent to have our child use sunscreen s/he has brought or the Sports Camp has supplied, which is approved by the FDA for over the counter use to avoid over exposure to the sun. Our child may be assisted by camp staff if s/he requests.

Signature _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Sports Camp staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Sports Camp program.

IMMUNIZATION HISTORY– This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td Date _____ Date _____ Date _____ Date _____ Date _____

Polio Date _____ Date _____ Date _____ Date _____ Date _____

MMR Date _____ Date _____ Date _____

Hemophilus Influenzae type b (Hib) Date _____ Date _____ Date _____ Date _____

Hepatitis B Date _____ Date _____ Date _____ Date _____

Varicella Date _____ Date _____

Pneumococcal

Conjugate (PCV) Date _____ Date _____ Date _____ Date _____ Date _____

Other _____ Date _____ Other _____ Date _____ Other _____ Date _____

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at Sports Camp.

Code: S = Satisfactory X = Not Satisfactory (Explain) 0 = Not Examined

General Appearance _____

Genitalia -_____

Height _____ ---- Weight _____ Blood Pressure _____ Posture & Spine _____ Throat - Tonsils _____

Nose_____ Teeth _____ Abdomen _____ Hernia _____ Feet_____ Lungs _____ Skin _____

Hgb. Test (Date) _____ Urinalysis (Date) _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____ Ears _____ Hearing _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

_____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp:

Special Diet _____

Special Medicine (dose, route of administration, when should it be administered) _____

Is parent/guardian sending special medicine? _____

Activity Restrictions _____

Swimming _____ Diving _____

General Appraisal:

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Sports Camp activities, except as noted above.

_____M.D. _____

EXAMINING PHYSICIAN (SIGNATURE) PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ ZIP CODE _____