



## 2018 Health Form

**Important:** This form must be **completed** within one year prior to camp **and signed by parent or guardian** before the child may take part in activities with Future Stars.

**Return via - Email:** stjoes@fscamps.com **Fax:** 631-207-8535 or **Mail to:** P.O. Box 3259 Patchogue, NY 11772

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Parent 1: \_\_\_\_\_ Parent 2: \_\_\_\_\_  
 Cell Phone: Parent 1 \_\_\_\_\_ Parent 2 \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone(s): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If not available in emergency, please notify:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medical Insurance/Medicaid Number:** \_\_\_\_\_

**Health History/** Is the health of the camper, in general, good? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Immunization History/**Please list date(s) for the following **OR** attach immunization records from doctor's office:

Diphtheria _____	Mumps _____	Rubella _____
Measles _____	Polio _____	Tetanus _____
Hepatitis B _____	Varicella (Chicken Pox) _____	
	Haemophilus Influenza Type B _____	

Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Allergies or Sensitivity -** Is the camper subject to any of the following conditions?

Rheumatic Fever	Behavior Problem	Penicillin	Mumps
Sinus Trouble	Drug Allergies	Hay Fever	Asthma
Ear Infection	Fainting Spells	Chicken Pox	Other:
Convulsions	Ivy Poisoning	German Measles	
Diabetes	Insect Stings	Measles	

Operations or Serious Injuries (Dates): \_\_\_\_\_

Chronic or Recurring Illness: \_\_\_\_\_

Other Diseases: \_\_\_\_\_

**Providing an "EPI-PEN" OR MEDICATION ? Our "Epi-Pen/Medication Standing Order Form" MUST be submitted.**

Please provide any other additional information and/or physical limitations that you want the Camp Director to be aware of:  
 If the camper has any physical or medical conditions, or is on medication the office and the Camp Director must be notified.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Parents Authorization**

This health history form is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by the examining physician and me. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(Must be signed)