



Future Stars at SUNY Old Westbury –

Camper Health Form 2025

Important (1of2): This form must be completed and signed by parent/guardian before the child may begin camp.

Health Forms are required to be completed each summer.

Upload to your **CampInTouch Account** OR Scan to oldwestbury@fscamps.com OR Mail to – **PO Box 57, Jericho NY 11753**

Camper's Name _____ Birth Date _____ ☐ Male ☐ Female
Home Address _____ City/State/Zip _____
Parent/Guardian _____ Cell/Work # _____
Parent II /Guardian II _____ Cell/Work # _____
Emergency Contact _____ Cell/Work # _____

Health History – Check any that apply

☐ Allergies _____ ☐ Heart Defect/Disease _____
☐ Asthma _____ ☐ Injuries _____
☐ Diabetes _____ ☐ Physical Limitations _____
☐ Dietary Restrictions _____ ☐ Seizures _____
☐ Disabilities/Chronic Illness _____ ☐ Surgeries _____

Immunization History

Upload – *separately* – copy of your child's immunizations to your **CampInTouch Account** OR Scan to oldwestbury@fscamps.com

Please provide any other pertinent information that you wish the Camp & Camp Health Director to be aware of.

If your child has any physical or medical matters or is on medication the Camp & Camp Health Director must be notified.

Parent/Guardian Authorization

I hereby give permission for the person herein described to engage in all prescribed camp activities, except as noted by me and/or camper's medical professional. I hereby give permission for camp medical staff to provide routine treatment to my child. In the event I cannot be reached in an emergency, I hereby give my permission for the camp to place my child in the care of a medical professional for medical services and treatment as deemed necessary with respect to my child's health and safety.

Signature _____ Date _____

Important (2of2): This section of the form must be filled out by your physician **OR** a copy of your child's most recent physical can be attached to this form. *(Must be valid within last year)*

Physician Authorization

Camper (name) _____ was examined by me **on (date)** _____ and was found to be in good general health and able to participate in all camp activities and athletic programs.

Restrictions (if applicable) _____

Physician Name & Address _____

Physician Signature / Stamp _____

Date _____