Future Stars Day Camps 2017 Health Form

Important: This form must be completed within one year prior to camp and signed by parent or guardian before the child may begin camp.

Mail to: 546 Bedford Rd, Armonk, NY 10504 Fax: 914-273-8506 or Email: purchase@fscamps.com

Camper's Name: _____Age: _____Birthdate: _____Sex: ____
Parent 1: _____Parent 2: _____
Home Phone: _____ Work Phone(s): _____
Cell 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:

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: _____

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 problems, 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)