Future Stars Day Camps 2010 Health Form

Important: This form must be completed within one year prior to camp and signed by parent/guardian and physician before the child may begin camp.
Mail to: P.O Box 396, Old Westbury NY 11568 or Fax: 914-273-8506

Camper's Name:_______________________________________Age:______Birthdate:_________Sex:____
Mother's Name:_______________________________Father's Name_______________________________
Home Phone:_______________WkPhone(Mother):_______________WkPhone(Father):_______________
Cell Phone(s)/Beeper etc.:____
Address:___________________________________City:___________________State:______Zip:________

If not available in emergency please notify:
Name:____Phone:___________________
Address:___________________________________City:____________________State:_______Zip:______

Medical Insurance/Medicaid Number:____

Immunization History/Please list date(s) for the following:

Diphtheria ___________ Mumps _____________ Rubella _________
Measles ___________ Polio _____________ Tetanus_________
Hepatitis B ___________ Varicell(chicken pox) ___________
Haemophilus influenza type b ___________

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	Sleep Walking
Convulsions	Ivy Poisoning	German Measles	Bed Wetting
Diabetes	Insect Stings	Measles	

Operations or Serious Injuries (Dates):____
Chronic or Recurring Illness____

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

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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)

Physician Authorization

Name: ______________________________ was examined on __________ and was found to be in good general health and able to participate in all required athletic programs. Restrictions:____

Doctor's Name______________________________________ Phone Number__________________

Signature____**Date**______________

(Must be signed)