# RANDALL'S ISLAND SPORTS CAMP

## *HEALTH RECORD/MEDICAL RELEASE FORM*

This form must be completed and returned before camp enrollment dates in order for the camper to be permitted to participate in any camp activities. **Side A** - To be filled out by parent before presenting to camper's physician. **Side B** - To be filled out by camper's physician.

**SIDE A PERSONAL INFORMATION**

Camper's Last Name_____ First Name_____ Birthdate_____ ❑ M ❑ F

Specify camp(s) child will be attending

_____

Address_____ City _____ State_____ Zip_____

Home Phone_____E-mail Address _____

Mother's Name_____Father's Name_____ Daytime Phone _____Daytime Phone_____

Place of employment _____ Place of employment _____

Health Insurance Carrier _____ Policy Number _____

Plan Number _____ Is physician authorization needed? _____

**In case of emergency, please notify**_____

If neither parent or guardian are available in an emergency, please contact:

1. _____ Daytime Phone _____
2. _____ Daytime Phone _____

**HEALTH HISTORY** (Please check approximate dates that camper suffered from allergies, diseases, and conditions listed below).

| **Diseases** | **Allergies** | **Other** |
|---|---|---|
| ❑ Chicken Pox_____ | ❑ Hay Fever_____ | ❑ Ear Infections_____ |
| ❑ Measles_____ | ❑ Poison Ivy_____ | ❑ Rheumatic Fever_____ |
| ❑ German Measles_____ | ❑ Insect Stings_____ | ❑ Convulsions_____ |
| ❑ Mumps_____ | ❑ Penicillin_____ | ❑ Diabetes_____ |
| ❑ Asthma_____ | ❑ Other Drugs_____ | ❑ Behavior _____ |
| | | ❑ Concussion _____ |
| | | ❑ Other _____ |

Please list any past illnesses (contagious and non-contagious):_____

Please list any operations or serious injuries (include dates):_____

Has camper ever been hospitalized?_____

Does camper have any chronic or recurring illness?_____

Is there anything else in campers health history that the camp staff should know?_____

Are there any activities from which the camper should be restricted?_____

Are there any specific activities that should be encouraged?_____

Will the camper be taking any medication at camp?_____

Does the camper wear any medical appliances (glasses, contact lenses, orthodonture, etc.)?_____

**IF MEDICATION IS REQUIRED, IT MUST COME IN THE ORIGINAL CONTAINER WITH USAGE/DOSAGE/ INSTRUCTIONS CLEARLY PRINTED ON LABEL. A DOCTOR'S NOTE AND PARENTS NOTE MUST ALSO BE SENT.**

**CONSENT FOR MEDICAL TREATMENT**

I do hereby authorize that all of the above information is correct and that my child is fully able to participate in all Randall's Island Sports Camp activities without need of individual or specialized attention or medical regimen. I agree to notify Randall's Island Golf Center of any changes in my child's physical or mental health between the dates of enrollment and the start of the camp as well as during camp. I hereby
consent and authorize the administration of all medical treatments advisable or necessary under the judgement of the accredited camp trainers, emergency room physicians or any other clinical physicians with the understanding that I will be notified as soon as possible.

Name_____

Relationship_____

Signature _____ Date_____

Phone_____

Continued on next page

To be filled out by camper's physician.
Name of Camper _____ Name of Physician

_____

**IMMUNIZATION HISTORY**

Please provide us with a record of basic immunization and most recent booster doses for the camper listed above.

DTaP, DTP, DT, TD_____ Date_____ Date_____ Date_____ Date _____
Polio_____ Date_____ Date_____ Date_____ Date_____
Measles_____ Date_____ Date_____ Date_____ Date_____
Rubella_____ Date_____ Date_____ Date_____ Date_____
Mumps_____ Date_____ Date_____ Date_____ Date_____
Hib_____ Date_____ Date_____ Date_____ Date_____
Hepatitis B_____ Date_____ Date_____ Date_____ Date_____
Varicella_____ Date_____ Date_____ Date_____ Date_____
PCV_____ Date_____ Date_____ Date_____ Date_____
Date of most recent Tetanus Shot _____
PPD-MANTOUX _____ Date Read _____

Most Recent Tuberculin Test Given _____ Result _____ ❑❑

MM

**MEDICAL EXAMINATION**

Examination must be performed no more than 12 months prior to arrival at camp.
CODE: S = Satisfactory
X = Not Satisfactory (explanation required)
O = Not examined

General Appearance _____ Height _____Weight _____ Blood Pressure _____
Hgb. Test _____ Urinalysis_____ Posture & Spine _____ Throat - Tonsils _____
Eyes _____Vision _____ Glasses _____
Extremities _____ Heart _____Ears _____Hearing _____
Feet _____ Lungs _____Skin _____ Nose _____
Teeth_____Abdomen_____Hernia _____ Genitalia _____
Neurological Findings:

_____

Allergies (please specify):

_____

Please describe any abnormal findings and/or handicapping conditions:

_____

Has child ever received products containing horse serum? _____

**RECOMMENDATION AND RESTRICTIONS DURING CAMP**

Special Diet _____
Special Medicine Needed _____ Is Parent Sending Medicine?____
Strenuous Activity _____
General Appraisal_____

**DOCTOR'S RELEASE**

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 all Randall's Island Sports Camp activities, except as noted above.
Examining Physician Signature

_____

Physician Name (please print)_____
Telephone _____
Address _____ Zip Code

_____

Date of Examination_____

Please mail completed form to: Randall's Island Golf Center, 1 Randall's Island, NY, NY 10035