

## Purchase Sports Camp Medical Form 2017

Manhattanville College \* 2900 Purchase Street, Purchase, NY 10577 \* (914) 315-7507

Mailing address: PO Box 398 Purchase, NY 10577-0398

June 26th-August 11th \* Monday-Friday \* Hours: 9:00am-4:00pm

### **Camper Information:**

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Age as of July 1 2017 \_\_\_\_\_

Grade (in September 2017) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

### **Emergency Contact Information:**

Emergency Contact Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

### **Medical Information:**

Name of Medical Insurance Carrier \_\_\_\_\_

\_\_\_\_\_  
Medical Insurance Number \_\_\_\_\_ Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

### **Please provide the dates of your child's last immunization for the following:**

Haemophilus influenza Type B \_\_\_\_\_ Mumps \_\_\_\_\_ Tetanus \_\_\_\_\_

Varicella (Chicken Pox) \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Polio \_\_\_\_\_ Diptheria \_\_\_\_\_

Would you rate your child's overall health as good? \_\_\_ Yes \_\_\_ No

When was your child's last physical? \_\_\_\_\_

**Does your child have a history of suffering from any of the following conditions? If so, please provide the date of the injury/illness.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Concussion(s)       | <input type="checkbox"/> Skull fracture(s)   | <input type="checkbox"/> Rib injuries                 |
| <input type="checkbox"/> Food allergies *    | <input type="checkbox"/> Arm injuries        | <input type="checkbox"/> Leg injuries                 |
| <input type="checkbox"/> Hand injuries       | <input type="checkbox"/> Foot injuries       | <input type="checkbox"/> Muscle strains               |
| <input type="checkbox"/> Frequent headaches  | <input type="checkbox"/> Heat exhaustion     | <input type="checkbox"/> Haemophilus influenza type b |
| <input type="checkbox"/> Diphtheria          | <input type="checkbox"/> Skin disorders      | <input type="checkbox"/> Hepatitis B                  |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Hay fever                    |
| <input type="checkbox"/> Sinus trouble       | <input type="checkbox"/> Drug allergies**    | <input type="checkbox"/> Chicken pox                  |
| <input type="checkbox"/> Ear infections      | <input type="checkbox"/> Fainting spells     | <input type="checkbox"/> German measles               |
| <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Measles             | <input type="checkbox"/> Polio                        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Scarlet fever                |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Abnormal bleeding   | <input type="checkbox"/> Loss/impairment of an organ  |
| <input type="checkbox"/> Bowel cramps        | <input type="checkbox"/> Varicella           | <input type="checkbox"/> Mononucleosis                |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Wears glasses       | <input type="checkbox"/> Neck injuries                |
| <input type="checkbox"/> Difficulty hearing  | <input type="checkbox"/> Back injuries       | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Frequent colds      | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Nose bleeds                  |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Thyroid disorders            |
| <input type="checkbox"/> Stomach ulcers      | <input type="checkbox"/> Other               |   |

\* If yes, which foods is your child allergic to, and what is the reaction?

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\*\*If yes, which drugs is your child allergic to, and what is the reaction?

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Has your child had any operations or serious injuries? If yes, please provide dates.

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Does your child have any chronic or recurring illness?

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Is your child currently taking any medication? If so, please provide the name and dosage of the medication, as well as the condition for which he or she is taking the medication. If there are specific instructions regarding the medication (ex. it must be taken with food), please provide that information as well.

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Please list any other information regarding your child's medical conditions or physical limitations that you would like the Camp Director to be aware of.

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## Parental Waiver and Consent Form

At any time before opening day or during the camp session, Purchase Sports Camp, LLC retains the right to cancel the enrollment agreement if we determine that the physical, mental, or emotional condition of the child would prevent him/her from participating safely and satisfactorily in our program or interacting positively with other campers.

Purchase Sports Camp, LLC can initiate the cancellation of this agreement and the dismissal of the child if, during the camp season, the child or his/her agents exhibit unacceptable behavior which prevents our staff from safely supervising him/her or proves detrimental to himself/herself, other campers, or staff members as determined by the Camp Director.

As the parent or legal guardian of the child named above, I hereby give my full consent and approval for my child to participate as a camp member in all the sports, including swimming designated by Purchase Sports Camp.

I understand that there are certain risks of injury inherent in the practice and play of these sports, as well as in traveling and other related activities incidental to my child's participation, and I am willing to assume these risks on behalf of my child. I hereby certify that my child is fully capable of participating in the designated sports and that my child is healthy and has no physical or mental disabilities or infirmities that would restrict full participation in these sports, except as listed above.

I give permission for my son/daughter to be medically treated in the event that I am not available for an emergency during Purchase Sports Camp. The above-mentioned person will be notified as soon as possible.

In addition to giving my full consent for my child's participation, I do hereby waive, release and hold harmless Purchase Sports Camp, its officers, coaches, sponsors, supervisors and representatives for any injury that may be suffered by my child in the normal course of participation in the designated sports and the activities incidental thereto, whether the result of negligence or any other cause.

Primary Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

To the best of my knowledge, the above information is accurate.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **A SEPARATE IMMUNIZATION RECORD FROM YOUR DOCTOR IS REQUIRED**

**Please give all forms to us with your application.**

**This form must be completed and signed AND separate immunization record received from doctor before child may participate.**

**Purchase Sports Camp**  
**Location address: 2900 Purchase Street**  
**Mailing address: PO Box 398**  
**Purchase, NY 10577-0398**

**Parent/Guardian's Agreement:**

I, \_\_\_\_\_, hereby allow the aforementioned camper to participate in all camp activities, except those noted by me and the child's physician. In the event that I am unable to be contacted during an emergency, I grant the camp-appointed physician permission to hospitalize and provide treatment for my child.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date