CAMP SPORTSPLEX

To be Completed by Physician

CHILD HEALTH AND IMMUNIZATION FORM

Forms must be handed in to Camp Medical Director by May 15

Child's Name _____ Sex: ❑ M ❑ F Date of Birth _____

Address _____

Parent Name _____ Home Phone _____

Work or Cell Phone _____

DTap or DT
1. _____
2. _____
3. _____
4. _____
5. _____

Hib
1. _____
2. _____
3. _____
4. _____

PCV
1. _____
2. _____
3. _____
4. _____

Influenza
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Varicella
1. _____
2. _____
Or had the disease:
❑ Yes ❑ No
Date: _____

Hep B
1. _____
2. _____
3. _____

Hep A
1. _____
2. _____

Rotavirus
1. _____
2. _____
3. _____

IVP
1. _____
2. _____
3. _____

MMR
1. _____
2. _____

Date of Exam: _____

Height _____
Weight _____
BP _____
Eyes _____
Ears _____
Lymph Nodes _____
Thyroid _____
Nose _____
Tonsils _____
Heart _____
Lungs _____
Hernia _____

Orthopedic _____
Structural _____
Posture _____
Feet _____
Scoloisis _____
Skin _____
Epilepsy _____
Nervous System _____
Speech _____
Nutrition _____
Urinalysis _____
OTHER _____

Physician MUST fill in box:

PARTICIPATION IN:

Regular Activities

Strenuous Activities

Swimming/Diving

Any Restrictions?

SPECIAL INSTRUCTIONS, ALLERGIES, **SPECIFIC MEDICATION ORDERS**, etc. _____

Doctor's Stamp

Physician's Signature _____

Phone# _____

Date _____

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www.sportsplex-nw.com

CAMP SPORTSPLEX

TO BE COMPLETED BY PARENT OR GUARDIAN

MEDICAL HISTORY

Forms must be handed in to Camp Medical Director by May 15

CHILD'S NAME: _____

Has your child ever had?: Chicken Pox_____ Pneumonia_____

Is your child subject to or ever been treated for: Fainting spells____ Headaches_____

Tonsillitis____ Abdominal pains____ Fractures____ Concussions_____ Hernia_____

If yes, please explain: _____

_____

Is your child prone to: Ear infections____ Sinus infections_____ Lung/kidney disorder____

Has your child been treated for any difficulties relating to the heart: _____

Is your child allergic to any drugs: Penicillin/Sulfur/Other: _____

Does your child have any allergies? (bee stings, pollen, food, etc._____

Does your child have Asthma: Yes____ No____

Is your child currently taking any medication? If so, what is the medication: _____

_____

If your child is taking medication during camp, please send in a note from a physician to authorize camp personnel to store and distribute the medication during the day.

Will you allow counselors to apply sunscreen to your child? ❑ Yes ❑ No

Does your child have experience swimming? _____

Any restrictions for swimming?_____

Physical Activity? _____

Has your child ever attended camp before? Please describeAny other concerns, or information that you feel would help us be responsive to your child's needs?_____

_____

I have read and am familiar with the terms and conditions contained in the waiver of liability listed below:
It is expressly agreed that use of any and all apparatus, appliances, facility privilege or any service whatsoever, owned and operated by Sportsplex shall be undertaken at my and my minor children's sole risk, and that I assume the risk of any injuries I or my minor children may suffer while using any of the equipment, facility privilege or any service of Sportsplex.
I understand that my signature here as a parent or legal guardian indicates that all the above information is correct, that my child is in satisfactory health with no specific health problems other than those noted above, that I agree to comply with all program policies and that I give permission for my child to participate in all program activities. I also give permission, in case of injury, for Medical personnel to administer first aid/treatment when the need for such treatment is immediate, and efforts to contact persons are unsuccessful, and to take my child to the hospital for treatment if necessary.

Signature:_____ Date:_____

ALL INFORMATION PROVIDED ON THIS FORM WILL REMAIN CONFIDENTIAL