



HEALTH RECORD/MEDICAL RELEASE FORM

Little Athletes/Multi-Sport/Gymnastics Holiday Camps

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 _____

Guardian #1 _____ Guardian #2 _____

Daytime Phone _____ Daytime Phone _____

Place of employment _____ Place of employment _____

Health Insurance Carrier _____ Policy Number _____

Plan Number _____ Is physician authorization needed? YES NO

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

Chicken Pox _____

Measles _____

German Measles _____

Mumps _____

Asthma _____

Allergies

Hay Fever _____

Poison Ivy _____

Insect Stings _____

Penicillin _____

Other Drugs _____

Other

Ear Infections _____

Rheumatic Fever _____

Convulsions _____

Diabetes _____

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 Chelsea Piers Camp activities without need of individual or specialized attention or medical regimen. I agree to notify Chelsea Piers 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 _____

SIDE B: 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 _____ Date _____

Polio _____ Date _____ Date _____ Date _____ Date _____ Date _____

Measles _____ Date _____ Date _____ Date _____ Date _____ Date _____

Rubella _____ Date _____ Date _____ Date _____ Date _____ Date _____

Mumps _____ Date _____ Date _____ Date _____ Date _____ Date _____

Hib _____ Date _____ Date _____ Date _____ Date _____ Date _____

Hepatitis B _____ Date _____ Date _____ Date _____ Date _____ Date _____

Varicella _____ Date _____ Date _____ Date _____ Date _____ Date _____

PCV _____ Date _____ Date _____ Date _____ Date _____ Date _____

Date of most recent Tetanus Shot _____

PPD-MANTOUX _____ Date Read _____

Most Recent Tuberculin Test Given t _____ Result _____
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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? YES NO

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 Chelsea Piers Camp activities, except as noted above.

Examining Physician Signature _____

Physician Name (please print) _____

Address _____ Zip Code _____ Telephone _____

Date of Examination _____

PLEASE MAIL COMPLETED FORM TO:

Field House at Chelsea Piers - Pier 62 • New York, NY 10011 or FAX to: 212.336.6515