MAILING ADDRESS
Hofstra University Summer Camps
250 Hofstra University
Hempstead, NY 11549-2500
Phone: 516-463-2267
Fax: 516-463-6114

HOFSTRA
UNIVERSITY®
SUMMER CAMPS

Date______________

EMPLOYEE MEDICAL HISTORY FORM

To be filled in by parents/guardians of minors or by adult campers/staff members themselves.

Name____ **Birth Date** ____/ ____/_______ **Sex**______ **Age** _______
Last First M.I.

Parent or Guardian (or Spouse) ____Phone (_______)________________

Home Address ____
Street and Number City State ZIP Code

Business Address ____Phone (_______)________________
Street and Number City State ZIP Code

Second Parent or Guardian: ____

Home Address ____Phone (_______)________________
Street and Number City State ZIP Code

If not available in an emergency, notify: _________________________________Phone (_______)________________

Address ____
Street and Number City State ZIP Code

Health History:
(Check and give approximate dates.)

- ☐ Frequent Ear Infections __________
- ☐ Heart Defect/Disease __________
- ☐ Convulsions/Epilepsy __________
- ☐ Diabetes __________
- ☐ Bleeding/Clotting Disorder __________
- ☐ Hypertension __________
- ☐ Psychiatric Treatment __________
- ☐ Mononucleosis __________
- ☐ Asthma __________
- ☐ Allergies __________

Family Medical History

- ☐ Premature death related to cardiovascular disease
- ☐ Disability from cardiovascular disease at age <50 years
- ☐ Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan syndrome, arrhythmias, channelopathy, (ekg, long QT)

Has this camper ever required any psychiatric counseling or hospitalization?
____

Operations or serious injuries *(dates)*:__________________________________
____

Disability or chronic or recurring illness:__________________________________
____

Any specific activities to be encouraged or limited by physician's advice:
____

Other diseases or details of above: __________________________________
____

____
____

Name of family physician:_______________________Phone___________

Do you carry family medical/hospital insurance?______________________

If so, indicate carrier:____

Policy or group no.:____

Suggestions or health-related information for camp personnel:__________
____
____
____

IMPORTANT — BOX A OR B MUST BE COMPLETED FOR EMPLOYEE'S ATTENDANCE.

A

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:
I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me and/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for off-campus trips.

Signature of parent or guardian or adult camper/staffer ____

B

I do not wish to give the camp permission to give emergency care if I cannot be reached.

Signature ____

35256:1/12

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EMPLOYEE PHYSICAL EXAMINATION

Immunization history must be attached to this form.

(Please print clearly.)

Employee's Name ____________________ Birth Date___ /___ /________
Last First Middle Initial

PHYSICAL CONDITION :

Date Examined: ____________

Height (Ht.)	Weight	Blood Pressure	Urinalysys (VA)	Hemoblobin (Hg)

ALLERGIES (food, drugs, plants, insects, etc.) **:** ____________

PHYSICAL EXAM: ❑ Heart murmur ❑ Physical stigmata of Marfan Syndrome ❑ Femoral vs. radial pulses to exclude aortic coarctation ❑ Brachial artery blood pressure

PERSONAL MEDICAL HISTORY: ❑ Exertional chest pain/discomfort ❑ Syncope/near syncope ❑ Prior recognition of a heart murmur ❑ Excessive, unexplained exertional dysprea or fatigue ❑ Prior recognition of a heart murmur ❑ Elevated blood pressure

FAMILY MEDICAL HISTORY: ❑ Premature death related to cardiovascular disease ❑ Disability from cardovascular disease at age 50+ ❑ Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan syndrome, arrhythmias, channelopathy (eg, long QT)

The applicant is under the care of a physician for the following condition(s): ____________

____

____

In my opinion the above condition(s) does____ /does not____ preclude his/her participation in an active camp program.

Current treatment *(include current medications)*: ____________

____

Explanation of any reported loss of consciousness, convulsion or concussion:

____

____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any treatment to be continued at camp: ____________

ANY MEDICATION to be administered at camp? ❑ Yes ❑ No

Name of medication(s): ____________

Dosage: amount(s) to be given ____________

time(s) to be given ____________

Side effects: to report ____________

to expect ____________

Diagnosis ____________

Any medically prescribed dining plan or dietary restrictions ____________

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child ____________ receive the medication as prescribed on this form by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse or other assigned person will administer the medication.

____
Signature (Parent/Guardian)

Address: ____________

Telephone: Home____________ Work____________

Cell____________ Other____________ Date ______

ADDITIONAL INFORMATION:

Licensed Physician's Signature ____________

Phone____________ Address ____________

Date of form completion __________ by____________

Initial if completed by nurse or physician's assistant: ____________

Physician's Stamp: