Phone: (631) 342-9033
Fax: (631) 342-0408
Address: 1745 Express Drive North,
Hauppauge, NY, 11787

MEDICAL HISTORY FORM

This form is to be filled out by the parent/guardian of the camper. This medical history MUST be completely filled out and returned with your child's registration.

Campers Name_____ **Birth Date**____/____/_____

Home Address_____ **Male**____ **Female**_____

Mother/Guardian _____ **Work/Cell #**_____

Father/Guardian _____ **Work/Cell #**_____

Emergency Contact: Name_____

Contact Number_____ **Relationship to camper**_____

Health History: (Check box if applicable and use line to explain)

☐Allergies	_____	☐Heart Defect/Disease	_____
☐Asthma	_____	☐Hyper/Hypotension	_____
☐Bleeding/Clotting Disorder	_____	☐Mononucleosis	_____
☐Diabetes	_____	☐Operations/ Injuries	_____
☐Dietary Restrictions	_____	☐Physical Limitations	_____
☐Disabilities/Chronic illness	_____	☐Psychiatric Treatment	_____
☐Frequent Ear Infections	_____	☐Seizure Disorders	_____
☐Medications Taken	_____	☐ Other	_____

Pertinent Family History: _____

Name of Campers Physician: _____ Phone #:_____

Do you carry family medical/hospital insurance ☐Yes ☐No

If yes, indicate carrier: _____ Policy or group number_____

IMPORTANT- PARENT/GUARDIAN MUST SIGN

I hereby give permission for camp medical staff to provide routine treatment to my child. I understand that I am responsible for my child's medical or medication needs and further agree that in an emergency and/or if I cannot be reached employees, may take whatever action is deemed necessary with respect to my child's health and safety. I authorize Play Like A Pro, its agents and employees, to place my child, at their discretion and without my further consent, in a hospital or in the care of a medical professional for medical services and treatment, and to arrange necessary related transportation for me and/or my child. I understand that I will be fully responsible for any fees and expenses for any service and/or treatment..

X_____ Date_____

Date of Physical Exam
_____

Physician's Stamp and Signature:

PHYSICAL EXAMINATION

To be filled out by your physician. Campers will not be permitted to attend camp unless this form is completed and returned before the first day of camp.

Campers Name_____ **Birth Date**____/____/_____

PHYSICAL CONDITION: Height_____ Weight_____ Blood Pressure_____

Camper is under the care of a physician for the following condition(s) _____

CURRENT TREATMENTS (INCLUDE MEDICATIONS):_____

LIST ALL FOOD AND/OR DRUG ALLERGIES: _____

PHYSICAL EXAM:

☐Heart Murmur
☐Physical Stigmata of Marfan syndrome
☐Femoral vs. radial pulses to exclude aortic coarctation
☐Brachial artery blood pressure
☐Exertional chest pain/discomfort
☐Syncope/nears syncope
☐Prior recognition of a heart murmur
☐Excessive, unexplained exertional dyspnea or fatigue
☐Elevated blood pressure

FAMILY MEDICAL HISTORY:

☐Premature death related to cardiovascular disease
☐Disability from cardiovascular disease at age 50+
☐Hypertrophic cardiomyopathy, dilated cardiomyopathy, marfan syndrome, arrhythmias, channelopathy (eg. Long QT)

This camper was examined by me and was found to be in good general health and able to participate in all athletic programs. ☐Yes ☐ No If No please explain._____

Camper Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT Series, Diphtheria, Pertussis, Tetanus **OR**	1 2 3	1 2 3
TD Series, Tetanus, Diphtheria **OR**		
Tetanus		
Polio Series		
MMR Series		
HIB Series		
Hepatitis B Series		
Chicken Pox (illness or vaccine)		
Meningitis		