



# HOFSTRA SUMMER CAMPS

A choice that can change your child's life!

learn.

play.

grow.

## IMPORTANT MEDICAL INFORMATION

All medications both prescription and non-prescription (Tylenol, Benadryl, etc.) must be brought into the camp RN's along with a completed "**Authorization for Administration of Medication**" (located at the bottom of the physical examination form). A separate **Authorization for Administration of Medication** form must accompany each medication. Please have your physician sign and stamp the form.

- All medications will be stored in our infirmary and administered as prescribed by your physician.
- Campers are not permitted to carry medications at any time.

Nurses will be available on

- Wednesday, June 27 from 6 – 8 p.m. at the camp office and on
- Thursday, June 28 from 10 a.m. to 2 p.m. at the camp infirmary located in Room 131 of the Physical Education Building.

Thank you, Hofstra Summer Camps

### Summer Camp Office

Meadowbrook Parkway to Exit M4 - Route 24 West (Hempstead Turnpike). Heading west on Hempstead Turnpike, go under both walkways; after second walkway, make a right at the first light, Oak Street. Go down to the second entrance into Hofstra University, and we are the first building on the right-hand side, University College Hall.

### Physical Education Building

Meadowbrook Parkway to Exit M4 - Route 24 West (Hempstead Turnpike). Heading west on Hempstead Turnpike, go under walkway to the first light. Make a right into the main entrance of campus. Go to second stop sign and make a right. The first building on your right-hand side will be the Physical Education Center.

**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 \_\_\_\_\_

# MEDICAL HISTORY

To be filled in by parents/guardians of minors or by adult campers/staff members themselves. Your child's registration will not be processed until the medical history is entirely completed and signed, do not leave any lines blank, enter N/A if not applicable.

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 CAMPER'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 \_\_\_\_\_

**Medical History Form must be returned with your child's registration form.  
The Physical Examination Form must be returned in order for your child to attend camp no later than May 15!**

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

CAMPERS WILL NOT  
BE PERMITTED TO ATTEND  
CAMP UNLESS THIS FORM IS  
RETURNED AND COMPLETED.

# PHYSICAL EXAMINATION

**Immunization history must be attached to this form.**

(Please print clearly.)

Camper's Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Middle Initial

### PHYSICAL CONDITION :

Date Examined: \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
Height (Ht.) Weight Blood Pressure Urinalysis (VA) Hemoglobin (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 dyspnea or fatigue  Prior recognition of a heart murmur  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)

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 \_\_\_\_\_

### ADDITIONAL INFORMATION:

Licensed Physician's Signature \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Date of form completion \_\_\_\_\_ by \_\_\_\_\_

Initial if completed by nurse or physician's assistant: \_\_\_\_\_

### 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 \_\_\_\_\_

Physician's Stamp: