

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.)

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 _____
- Diabetes _____

- Bleeding/Clotting Disorder _____
- Hypertension _____
- Psychiatric Treatment _____
- Mononucleosis _____
- Asthma _____
- Allergies _____

Diseases

- Chicken Pox _____
- Measles _____
- German Measles _____
- Mumps _____

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:

Dietary restrictions: _____

Current medications (send with instructions): _____

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: _____

(For female): Has this person menstruated? _____

If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

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 FORMS MUST BE RETURNED IN ORDER FOR CHILD TO ATTEND CAMP!
ALL FORMS MUST BE RETURNED BY MAY 1, REGARDLESS OF THE SESSION YOUR CHILD IS ATTENDING.**

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

PHYSICAL EXAMINATION

(Please print clearly.)

Camper's Name _____ Birth Date ____/____/____
 Last First M.I.

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses:

Vaccines	Year of Basic Immunization	Year of Last Booster	Physical Condition
Diphtheria Pertussis (Whooping Cough) Tetanus or } DPT*	1 2 3	1 2	_____
Tetanus Diphtheria or } TD*			_____
Tetanus			_____
Oral Polio (Sabin) * TOPV			Blood Pressure (BP)
Injectable Polio (Salk)			_____
Measles (hard measles, red measles, rubeola)			Hemoglobin (Hg)
Mumps			_____
Rubella (German measles, Three-day measles)			Urinalysis (VA)
Other			_____
Tuberculin test given _____ (most recent)			_____

Date Examined: _____

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:

Does applicant have epilepsy? Yes _____ No _____

Does applicant have diabetes? Yes _____ No _____

Recommendations and Restrictions While at Camp:

Any treatment to be continued at camp: _____

***ANY MEDICATION to be administered at camp:** Yes _____ No _____
 (specific dosages): _____

Any medically prescribed dining plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.): _____

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

Please provide separate sheets for each medication.

A. TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child _____ receive the medication as prescribed below 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:

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

I request that my patient, as listed below, receive the following medications:

Name of student: _____ Date of birth: _____

Diagnosis: _____

Name of medications: _____

Prescribed dosage, frequency and route of administration: _____

Time to be taken during camp hours: _____ Duration of treatment: _____

Possible side effects and adverse reactions (if any): _____

Other recommendations: _____

Name of licensed prescriber and title (Please print.): _____

Prescriber's signature: _____ Date: _____

Address: _____ Phone: _____