HOFSTRA SUMMER CAMPS
A choice that can change your child's life! learn. play. grow.

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.

Camper's Name _____ **Birth Date**____/____/_____ **Male** ☐ **Female** ☐

Home Address _____ **City** _____ **State** ____ **ZIP** _____

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

Pertinent Family History: _____

Name of Camper's 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, the University, through its agents and employees, may take whatever action is deemed necessary with respect to my child's health and safety. I authorize the University, 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. This completed form may be photocopied for off-campus trips.

X _____ _____ _____

Print Name **Signature** **Date**