250 Hofstra University Hempstead, New York 11549 / Phone - 516-463-CAMPS (2267) / Fax 516-463-6114

Date of Physical Exam
_____

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

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: _____

Is this camper fully immunized (please circle one): Yes / No

PHYSICAL EXAM:

☐Heart Murmur
☐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+

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		

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

All Medications both prescription and non-prescription must be brought to the camp infirmary along with this authorization form filled out by you the parent and by your child's physician.

Prescription medication must be in the original prescription bottle with your child's name on it.

Campers are at NO time allowed to carry medication with them.

TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN:

I request that my child (**Campers Name)** _____ Birth Date____/____/_____ 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) _____Date_____

TO BE COMPLETED AND SIGNED BY PHYSICIAN:
Recommendations and restrictions while at camp:

Patients Name_____

Name of medication(s): _____

Dosage: Amount(s) to be given: _____

Time(s) to be given: _____

Side effects: To report: _____

To expect: _____

Diagnosis: _____

Physician's Information:

Signature: _____

Address_____

_____

Phone number_____

Physician's Stamp:

Date of form completion_____