

**HEALTH RECORD/MEDICAL RELEASE FORM**  
**Little Athletes/Multi-Sport/Gymnastics Holiday Camps**

This form must be completed and returned before camp enrollment dates in order for the camper to be permitted to participate in any camp activities.  
**Side A** - To be filled out by parent before presenting to camper's physician. **Side B** - To be filled out by camper's physician.

**SIDE A: PERSONAL INFORMATION**

Camper's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Birthdate \_\_\_\_\_  M  F  
 Specify camp(s) child will be attending \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Guardian #1 \_\_\_\_\_ Guardian #2 \_\_\_\_\_  
 Daytime Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
 Place of employment \_\_\_\_\_ Place of employment \_\_\_\_\_  
 Health Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Plan Number \_\_\_\_\_ Is physician authorization needed?  YES  NO

**In case of emergency, please notify** \_\_\_\_\_

If neither parent or guardian are available in an emergency, please contact:

1. \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
 2. \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**HEALTH HISTORY** (Please check approximate dates that camper suffered from allergies, diseases, and conditions listed below).

<b>Diseases</b>	<b>Allergies</b>	<b>Other</b>
<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Ear Infections _____
<input type="checkbox"/> Measles _____	<input type="checkbox"/> Poison Ivy _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> German Measles _____	<input type="checkbox"/> Insect Stings _____	<input type="checkbox"/> Convulsions _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Other Drugs _____	<input type="checkbox"/> Behavior _____
		<input type="checkbox"/> Concussion _____
		<input type="checkbox"/> Other _____

Please list any past illnesses (contagious and non-contagious): \_\_\_\_\_

Please list any operations or serious injuries (include dates): \_\_\_\_\_

Has camper ever been hospitalized? \_\_\_\_\_

Does camper have any chronic or recurring illness? \_\_\_\_\_

Is there anything else in campers health history that the camp staff should know? \_\_\_\_\_

Are there any activities from which the camper should be restricted? \_\_\_\_\_

Are there any specific activities that should be encouraged? \_\_\_\_\_

Will the camper be taking any medication at camp? \_\_\_\_\_

Does the camper wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? \_\_\_\_\_

**IF MEDICATION IS REQUIRED, IT MUST COME IN THE ORIGINAL CONTAINER WITH USAGE/DOSAGE/INSTRUCTIONS CLEARLY PRINTED ON LABEL. A DOCTOR'S NOTE AND PARENTS NOTE MUST ALSO BE SENT.**

**CONSENT FOR MEDICAL TREATMENT**

I do hereby authorize that all of the above information is correct and that my child is fully able to participate in all Chelsea Piers Camp activities without need of individual or specialized attention or medical regimen. I agree to notify Chelsea Piers of any changes in my child's physical or mental health between the dates of enrollment and the start of the camp as well as during camp. I hereby consent and authorize the administration of all medical treatments advisable or necessary under the judgement of the accredited camp trainers, emergency room physicians or any other clinical physicians with the understanding that I will be notified as soon as possible.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

**SIDE B: To be filled out by camper's physician.**

Name of Camper \_\_\_\_\_ Name of Physician \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please provide us with a record of basic immunization and most recent booster doses for the camper listed above.

DTap, DTP, DT, TD \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Polio \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Measles \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Rubella \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Mumps \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Hib \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Varicella \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

PCV \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Date of most recent Tetanus Shot \_\_\_\_\_

PPD-MANTOUX \_\_\_\_\_ Date Read \_\_\_\_\_

Most Recent Tuberculin Test Given t \_\_\_\_\_ Result \_\_\_\_\_    
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**MEDICAL EXAMINATION** Examination must be performed no more than 12 months prior to arrival at camp.

CODE: S = Satisfactory  
X = Not Satisfactory (explanation required)  
O = Not examined

General Appearance \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Hgb. Test \_\_\_\_\_ Urinalysis \_\_\_\_\_ Posture & Spine \_\_\_\_\_ Throat - Tonsils \_\_\_\_\_

Eyes \_\_\_\_\_ Vision \_\_\_\_\_ Glasses \_\_\_\_\_

Extremities \_\_\_\_\_ Heart \_\_\_\_\_ Ears \_\_\_\_\_ Hearing \_\_\_\_\_

Feet \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_ Nose \_\_\_\_\_

Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Genitalia \_\_\_\_\_

Neurological Findings: \_\_\_\_\_

Allergies (please specify): \_\_\_\_\_

Please describe any abnormal findings and/or handicapping conditions: \_\_\_\_\_

Has child ever received products containing horse serum? \_\_\_\_\_

**RECOMMENDATION AND RESTRICTIONS DURING CAMP**

Special Diet \_\_\_\_\_

Special Medicine Needed \_\_\_\_\_ Is Parent Sending Medicine?  YES  NO

Strenuous Activity \_\_\_\_\_

General Appraisal \_\_\_\_\_

**DOCTOR'S RELEASE**

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in all Chelsea Piers Camp activities, except as noted above.

Examining Physician Signature \_\_\_\_\_

Physician Name (please print) \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

Date of Examination \_\_\_\_\_

**PLEASE EMAIL COMPLETED FORM TO [fh@chelseapiers.com](mailto:fh@chelseapiers.com)**