

**PERSONAL HEALTH AND MEDICAL RECORD  
TO BE COMPLETED BY A PARENT  
(Need not be completed by physician)**

**OVERNIGHT CAMP – SESSION III August 5<sup>th</sup> – 9<sup>th</sup>, 2018**

Camper Name \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**EMERGENCY CONTACTS**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Other Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Other Phone \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**

I have or am subject to (*check and give details*)

\_\_\_ Asthma \_\_\_ Convulsions \_\_\_ Heart Trouble \_\_\_ Diabetes \_\_\_ Fainting  
 \_\_\_ High Blood Pressure \_\_\_ Allergy or reaction to any toxin \_\_\_ Contact Lenses  
 \_\_\_ Any other condition that may require emergency or special care, medication or knowledge.

Explain \_\_\_\_\_  
 \_\_\_\_\_

**APPROVED FOR PARTICIPATION IN**

\_\_\_ Hiking and camping \_\_\_ Water activities \_\_\_ Competitive Sports

Explain any restriction or limitations \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS:**

**HAS HAD:**

	Month/Year Given	Check if Needed	Vaccination	Disease
Tetanus	_____	___	Measles	___
Diphtheria	_____	___	Mumps	___
Polio	_____	___	Rubella	___
Hepatitis B	_____	___	Whooping	
	_____		Cough	___
	_____		Chicken Pox	___

**MEDICAL HISTORY**

Date of most recent physical exam (month and year) \_\_\_\_\_

Do you have any current health problems? \_\_\_\_\_

Are you under medical care or taking any medicines? \_\_\_\_\_

Has there been any surgery, injury, illness, allergies or change in health status since last physical? \_\_\_\_\_

Is there disease of (or history of):

	No	Yes	Year	Details
Serious Illness	_____	_____	_____	_____
Serious Injury	_____	_____	_____	_____
Deformity	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Skin, Glands	_____	_____	_____	_____
Eyes, Ears	_____	_____	_____	_____
Nose, Sinus	_____	_____	_____	_____
Teeth, Tonsils	_____	_____	_____	_____
Dentures	_____	_____	_____	_____
Bridges	_____	_____	_____	_____
Chest, Lungs	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Murmur	_____	_____	_____	_____
Rheumatic Fever	_____	_____	_____	_____
Stomach, Bowels	_____	_____	_____	_____
Appendicitis	_____	_____	_____	_____
Kidney Infection	_____	_____	_____	_____
Urine Infection	_____	_____	_____	_____
Bed-Wetting	_____	_____	_____	_____
Hernia Rupture	_____	_____	_____	_____
Back, Limbs, Joints	_____	_____	_____	_____
Sleep Walking	_____	_____	_____	_____
Behavioral Condition	_____	_____	_____	_____
Other	_____	_____	_____	_____

**HEALTH INSURANCE INFORMATION**

Company Name \_\_\_\_\_ Policy # \_\_\_\_\_

Is this an HMO ? \_\_\_\_\_ Group # \_\_\_\_\_

**STAFF AUTHORIZATION**

To the best of my knowledge, the above history is correct and complete. I know of no reason to restrict my activity at the Baggett’s Court Vision Basketball Camp. I can participate in all activities except as specifically noted herein. In the event of an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and to order injection, anesthesia or surgery for me.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Baggett’s Court Vision  
P.O. Box 6874  
Lawrenceville, NJ 08648

***This form must be completed and signed in order for your child to attend Baggett’s Court Vision!!***