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

**DAY CAMP – SESSION I** June 22nd – 25TH, 2020

Camper Name_____ Email:_____

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:

| | Month/Year Given | Check if Needed |
|---|---|---|
| Tetanus | _____ | ___ |
| Diphtheria | _____ | ___ |
| Polio | _____ | ___ |
| Hepatitis B | _____ | ___ |
| | _____ | |
| | _____ | |

HAS HAD:

| | Vaccination | Disease |
|---|---|---|
| Measles | ___ | ___ |
| Mumps | ___ | ___ |
| Rubella | ___ | ___ |
| 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!!***