

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

DAY CAMP – SESSION II July 13th – 16th, 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:

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!!