



EMERGENCY NUMBER FORM CHILD PICK UP INFORMATION

Child's Name _____ Age _____ Date of Birth _____

Address _____ Sex M F

City _____ State _____ Zip _____

Please indicate with Whom the Camper Lives Mother/Father Mother Father Guardian/other

Father's Name: First _____ Last _____

Work# _____ Home# _____ Other# _____

Mother's Name: First _____ Last _____

Work# _____ Home# _____ Other# _____

Emergency Contacts During Program Hours (9:00AM—3:00PM)

You must provide us with a local contact person who can pick up your child if necessary

Primary Emergency Contact: _____ Relationship _____

Work #: _____ Home#: _____

Second Emergency Contact: _____ Relationship _____

Work #: _____ Home#: _____

Third Emergency Contact: _____ Relationship _____

Work #: _____ Home#: _____

Physician's Name: _____ Phone: _____

Insurance ID Information _____

Is there anyone else who has permission to pick your child up from camp? If they are not listed here, we will not allow them to take your child from camp.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____



2010

CHILD HEALTH AND IMMUNIZATION FORM

To be Completed by Physician

Child's Name _____ Sex: M F Date of Birth _____

Address _____

Parent Name _____ Home Phone _____

Work or Cell Phone _____

Dpt or DT	OVP	MMR	Measels	Mumps	Rubella
1. _____	1. _____	1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____	3. _____	3. _____
4. _____	4. _____				
5. _____	5. _____				

Hib	Hep B	Other	Varivax	Date of Exam:
1. _____	1. _____	1. _____	1. _____	_____
2. _____	2. _____	2. _____	Or had the disease: <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. _____	3. _____	3. _____	Date: _____	

Height _____	Orthopedic _____
Weight _____	Structural _____
BP _____	Posture _____
Eyes _____	Feet _____
Ears _____	Scoliosis _____
Lymph Nodes _____	Skin _____
Thyroid _____	Epilepsy _____
Nose _____	Nervous System _____
Tonsils _____	Speech _____
Heart _____	Nutrition _____
Lungs _____	Urinalysis _____
Hernia _____	OTHER _____

Physician MUST fill in box:

PARTICIPATION IN:

Regular Activities _____

Strenuous Activities _____

Swimming/Diving _____

Any Restrictions? _____

SPECIAL INSTRUCTIONS, ALLERGIES, SPECIFIC MEDICATION ORDERS, etc. _____

Doctor's Stamp

Physician's Signature _____

Phone# _____

Date _____



2010

MEDICAL HISTORY

TO BE COMPLETED BY
PARENT OR GUARDIAN

CHILD'S NAME: _____

Has your child ever had?: Chicken Pox _____ Pneumonia _____

Is your child subject to or ever been treated for: Fainting spells _____ Headaches _____

Tonsillitis _____ Abdominal pains _____ Fractures _____ Concussions _____ Hernia _____

If yes, please explain: _____

Is your child prone to: Ear infections _____ Sinus infections _____ Lung/kidney disorder _____

Has your child been treated for any difficulties relating to the heart: _____

Is your child allergic to any drugs: Penicillin/Sulfur/Other: _____

Does your child have any allergies? (bee stings, pollen, food, etc.) _____

Does your child have Asthma: Yes _____ No _____

Is your child currently taking any medication? If so, what is the medication: _____

Has your child ever attended camp before? Please describe Any other concerns, or information that you feel would help us be responsive to your child's needs? _____

I have read and am familiar with the terms and conditions contained in the waiver of liability listed below:

It is expressly agreed that use of any and all apparatus, appliances, facility privilege or any service whatsoever, owned and operated by Sportsplex shall be undertaken at my and my minor children's sole risk, and that I assume the risk of any injuries I or my minor children may suffer while using any of the equipment, facility privilege or any service of Sportsplex.

I understand that my signature here as a parent or legal guardian indicates that all the above information is correct, that my child is in satisfactory health with no specific health problems other than those noted above, that I agree to comply with all program policies and that I give permission for my child to participate in all program activities. I also give permission, in case of injury, for Medical personnel to administer first aid/treatment when the need for such treatment is immediate, and efforts to contact persons are unsuccessful, and to take my child to the hospital for treatment if necessary.

Signature: _____ Date: _____

ALL INFORMATION PROVIDED ON THIS FORM WILL REMAIN CONFIDENTIAL

Photo & Video Release

I _____ allow Sportsplex tennis staff members to photograph and video tape my child while at tennis camp at NYMA. The photographs and videos will be used solely for historical and/or marketing purposes, and names are never published or released.
(parents signature)