



2011

# 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—4:00PM) Extended Care (7:30—9:00AM/4:00—6:00PM)

The following contacts listed below will be able to pick up your child from camp. **If they are not on this list they will not be able to pick up your child. Primary Contact will receive text message and or email announcing club emergency closings or cancellations.** Please supply all information requested.

**Primary** Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Work #: \_\_\_\_\_ Home#: \_\_\_\_\_

Cell # \_\_\_\_\_ Carrier (Verizon, ATT etc) \_\_\_\_\_ email \_\_\_\_\_

**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 \_\_\_\_\_



2011

# 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 \_\_\_\_\_



# 2011 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: \_\_\_\_\_

If your child is taking medication during camp, please send in a note from a physician to authorize camp personnel to store and distribute the medication during the day.

Will you allow counselors to apply sunscreen to your child?  Yes  No

Does your child have experience swimming? \_\_\_\_\_

Any restrictions for swimming? \_\_\_\_\_ Diving?(under supervision) \_\_\_\_\_

Physical Activity? \_\_\_\_\_

Has your child ever attended camp before? Please describeAny 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