Summer Camp at Armonk Tennis Club

Health Form

Camper's Name: ______________________ Age: ________ Birthdate: ______________ Gender: __________

Address: ______________________ City: ______________ State: ______ Zip: __________

Home Phone: ______________________ Email: ______________________

Parent/Guardian 1: ______________________ Work #: ______________ Cell #: ______________

Parent/Guardian 2: ______________________ Work #: ______________ Cell #: ______________

Emergency Contact (if parent/guardian is not available): ______________________ Phone: ______________

Address: ______________________ City: ______________ State: ______ Zip: __________

Camper's Medical Insurance/Medicaid Number: ______________________

Doctor's Name: ______________________ Phone: ______________________

Is the camper, in general, in good health? ☐ Yes ☐ No

Please mark if the camper has been immunized against the following diseases (please provide doctor's records to document):

☐ Diphtheria ☐ Hepatitis B ☐ Measles ☐ Mumps ☐ Polio ☐ Tetanus

☐ Haemophilus Influenzae Type B ☐ Rubella (German Measles) ☐ Varicella (Chickenpox)

Please mark if the camper is subject to any of the following conditions:

☐ Asthma ☐ Drug Allergies ☐ Fainting Spells ☐ Measles ☐ German Measles ☐ Ivy Poisoning

☐ Diabetes ☐ Ear Infections ☐ Sleep Walking ☐ Mumps ☐ Chickenpox ☐ Insect Sting Allergies

☐ Convulsions ☐ Sinus Troubles ☐ Bed Wetting ☐ Hay Fever ☐ Rheumatic Fever ☐ Behavioral Problems

Operations or serious injuries (please include dates): ______________________

Chronic or recurring illnesses: ______________________

Other diseases or conditions: ______________________

Medications currently taking: ______________________

Additional information and/or physical limitations that the Camp Director should be aware of: ______________________

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This health history form is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by the examining physician and me. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named above.

Signature: ______________________ Date: ______________________

Important: In order for your child to participate in the summer camp program, this form must be completed in full with parent/guardian signature and returned to the address or fax number below within one year of the first day of camp.

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