



Future Stars Summer Camps – **Camper Health Form 2017**

Important (1of2): This form must be completed and signed by parent/guardian before the camper may begin camp.
 Mail to – **PO Box 396, Old Westbury NY 11568.** Fax to **(516) 876-3589.** Scan to **ow@fscamps.com**

Camper's Name _____ Birth Date ___ / ___ / ___ Male Female
 Home Address _____ City/State/Zip _____
 Mother/Guardian _____ Cell/Work # _____
 Father/Guardian _____ Cell/Work # _____
 Emergency Contact _____ Cell/Work # _____

Health History – Check any that apply

- | | |
|---|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart Defect/Disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Injuries _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Physical Limitations _____ |
| <input type="checkbox"/> Dietary Restrictions _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Disabilities/Chronic Illness _____ | <input type="checkbox"/> Surgeries _____ |

Please provide any other pertinent information that you wish the Camp & Camp Health Director to be aware of.
 If the camper has any physical or medical matters, or is on medication the Camp & Camp Health Director must be notified.

Parent/Guardian Authorization

I hereby give permission for the person herein described to engage in all prescribed camp activities, except as noted by me and/or camper's medical professional. I hereby give permission for camp medical staff to provide routine treatment to my child. In the event I cannot be reached in an emergency, I hereby give my permission for the camp to place my child in the care of a medical professional for medical services and treatment as deemed necessary with respect to my child's health and safety.

Signature _____ Date _____

Important (2of2): This section of the form must be filled out by your physician **OR** a copy of most recent physical including immunization history must be attached to this form. *(Must be valid within last year)*

Immunization History

Vaccines	Date of Immunization	Date of Last Booster
DPT / TD Series		
Tetanus		
MMR Series		
Polio		
Hepatitis B		
HIB		
Varicella (Chicken Pox)		

Physician Authorization

Camper (name) _____ was examined by me **on (date)** _____ and was found to be in good general health and able to participate in all camp activities and athletic programs.

Restrictions (if applicable) _____

Physician Name & Address _____

Signature _____ Date _____