



# 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):

- COVID-19\*     Diphtheria     Haemophilus Influenzae Type B     Hepatitis B     Measles
- Mumps     Polio     Rubella (German Measles)     Tetanus     Varicella (Chickenpox)

\*Please provide a copy of your child's vaccination record card.

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     Incontinence     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: \_\_\_\_\_

\_\_\_\_\_

*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.

