



## Camper Medical History and Health Form

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Phone: \_\_\_\_\_ WkPhone(Mother): \_\_\_\_\_ WkPhone(Father): \_\_\_\_\_

Cell Phone(s)/Beeper \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If unable to reach parent or guardian in an emergency, please notify**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Health Insurance Company and Policy Number** \_\_\_\_\_

**Immunization History** Please list date(s) for the following:

Diphtheria \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

Tetanus \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Varicella (chicken pox) \_\_\_\_\_ Haemophilus influenza type b \_\_\_\_\_

**Allergies/Sensitivity** Is the camper subject to any of the following conditions? Please circle no or yes

	No	Yes	If Yes, Please Explain
Rheumatic Fever	No	Yes	_____
Behavior Problem	No	Yes	_____
Penicillin	No	Yes	_____
Mumps	No	Yes	_____
Sinus Trouble	No	Yes	_____
Drug Allergies	No	Yes	_____
Hay Fever	No	Yes	_____
Asthma	No	Yes	_____
Ear Infection	No	Yes	_____
Fainting Spells	No	Yes	_____
Chicken Pox	No	Yes	_____
Sleep Walking	No	Yes	_____
Convulsions	No	Yes	_____
Ivy Poisoning	No	Yes	_____
German Measles	No	Yes	_____
Bed Wetting	No	Yes	_____
Diabetes	No	Yes	_____
Insect Stings	No	Yes	_____
Measles	No	Yes	_____

Operations or Serious Injuries (Dates): \_\_\_\_\_

Chronic or Recurring Illness? \_\_\_\_\_

Current injury/illness/infectious disease? \_\_\_\_\_

Please list all medications camper is currently taking: \_\_\_\_\_

**Please provide any other additional information about the camper's behavior and physical, emotional, or mental health or physical limitations that you wish the Camp Director to be aware of:**

**Please list any restrictions for this participant while at camp :**

**If the camper has any physical or medical problems, or is on medication the office and the Camp Director must be notified.**

### **Parent Authorization**

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 to order injection, anesthesia or surgery for my child as named above.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**(Must be signed)**

### **Physician Authorization**

Name: \_\_\_\_\_ was examined on \_\_\_\_\_ and was found to be in good general health and able to participate in all required athletic programs.

Restrictions: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**(Must be signed)**

**Important:** This form must be completed within one year prior to camp and signed by parent/guardian and physician before the child may begin camp.

**Mail to: Gotham Tennis Academy, 1560 Broadway, New York, NY 10036 or Fax to: 646-292-3511**  
[www.gothamtennis.com](http://www.gothamtennis.com)