STONY BROOK UNIVERSITY

Medical History Form

Name of Camp/Clinic: ____

Dates of Camp/Clinic Attending: ____

Personal Information

Name of Camper: _______________________________ Sex: M F Birthdate: __________________

Name of Parent: _______________________________________ Home Phone: _______________________

Address: ____ Work Phone: _______________________

____ Cell Phone: _______________________

Family Physician: ______________________________________ Phone Number: _____________________

Name of Person to contact in an emergency: ____

Relation to camper: ___________________________________ Daytime Phone Number: _____________________

Cell Phone Number: __________________________

Authorization for Medical Care

I hereby authorize a Staff member from Stony Brook University Athletics Department to be responsible for my son/daughter, __________________________, for the purpose of medical attention. I also grant permission for an emergency physician to examine and treat, hospitalize or secure treatment for my child in the event of an emergency.

Parent/Guardian Signature: ____ Date: ____________________

Assumption of Risk Statement

I have registered my child, ____________________________, for *The Summer Camps at Stony Book University.* I am fully aware of the actual and potential risks of personal injury (including serious injury and death) inherent in this activity. By signing below, I am asserting that I knowingly and voluntarily assuming all such risks for my child as well as medical expenses incurred as a result of injury or illness to my child. I am aware that *The Summer Camps at Stony Brook University* supplies an EXCESS ONLY policy and will cover, within the limits of the policy, any outstanding or denied bills.

Summer Camp Insurance Policy Summary

Please be advised that The Summer Camps insurance is a secondary carrier. The insurance plan pays the medical expenses actually incurred by an insured person when an accidental injury occurs while in attendance at the camp. This coverage is excess coverage and begins after the exhaustion of all other coverage for which the participant may be eligible. Should you have any questions please contact the Stony Brook Camp Office coordinator or director.

Medical History

Is child in good health: Yes No If not, please explain: ____

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Should nature or amount of physical exercise be limited: Yes No If so, please explain: ____

____

Does child have any allergies: Yes No If so, please explain: ____

____

Is child taking any medications regularly: Yes No If so, please explain: ____

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PROOF OF IMMUNIZATIONS ~ MUST BE COMPLETED BY YOUR PHYSICIAN'S OFFICE

NEW YORK STATE LAW REQUIRES ALL DATES FOR IMMUNIZATIONS

Dates Dates

Diptheria/Tetanus/Pertussis (DTP) _________________________ Poliomyelitis (IPV) ______________________

Measles/Mumps/Rubella (MMR) _________________________ Varicella (Chicken Pox) ____________________

Haemophilus Influenzae Type (Hib) _________________________ Hepatitis B _____________________________

Pneumococcal Conjugate (PCV) ___________________________

Physician's office verification of immunization:

(Please use office stamp or have physician sign) ____________________________________ Date: ______________