



**The Rinx Summer Hockey School**

Town Of Oyster Bay Ice Skating Center

1001 Stewart Ave, Bethpage, NY 11714

Phone: 516-797-4126 Fax: 631-232-3228

**MEDICAL FORM INSTRUCTIONS**

**Page 2 and Page 3 are to be completed and signed by the parent or guardian of the child.**

**Page 4 is to be completed and signed or stamped by your physician or medical personnel.** You may submit a computerized immunization sheet from the physician’s office as long as it has the physician’s signature or stamp and date.

**Please remember,** due to Nassau County Department of Health Regulations, children **may not attend** summer camp without a record of “**Current Immunizations**” on file at the camp.

**Please return the Medical Form with all parts completed by June 15, 2024. Thank you for your cooperation.**

Date \_\_\_\_\_

Grade as of Sept. \_\_\_\_\_

Name \_\_\_\_\_

(Office use only - Group: \_\_\_\_\_)



**The Rinx Summer Hockey School  
Current Health History including Current Immunization Record**

**PLEASE RETURN TO CAMP OFFICE PRIOR TO JUNE 15, 2024**

Pages 2 and 3 to be completed by the Parents/Guardians of Camper

Child's Name: \_\_\_\_\_ M / F: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age at Camp: \_\_\_\_\_ Grade as of September \_\_\_\_\_

Home address: \_\_\_\_\_

Custodial parent / guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home address: \_\_\_\_\_ Cell: \_\_\_\_\_

Business address: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Second parent or guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home address: \_\_\_\_\_ Cell: \_\_\_\_\_

Business address: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

**Emergency Contact – If I am not available in an emergency, notify: (Local contact please)**

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

Address: \_\_\_\_\_ Cell: \_\_\_\_\_

**Insurance Information (In case of Emergency)**

Is the participant covered by Medical Insurance? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, indicate carrier or plan name: \_\_\_\_\_ Group #: \_\_\_\_\_

Carrier address: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relation to participant: \_\_\_\_\_

Social security number of policyholder or insurance ID number: \_\_\_\_\_

**Primary Care Doctor**

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

Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

**Dentist Information**

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

Dental insurance carrier: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relation to participant: \_\_\_\_\_ Policy number: \_\_\_\_\_

**Please be advised that camps are now required by NYS DOH to get written parental permission for children to carry and apply themselves with sunscreen and bug spray. This also holds true even if a counselor, nurse, or EMT is applying the sunscreen to campers. I give my Child, my Child's Counselor, and the Camp Nurse/EMT permission to carry and apply sunscreen and or bug spray on my child, if needed, during the camp day.**

**Date** \_\_\_\_\_

# Current Camper Health History

Date: \_\_\_\_\_

Camper Name: \_\_\_\_\_

**General Questions** (Explain "yes" answers below)

(Does/Has) the participant:		Yes / No	Yes / No
1. Have any recent injury, illness?			15. Ever had problems with joints?
2. Have a chronic or recurring illness / condition?			16. Have an orthodontic appliance being brought to camp?
3. Ever been hospitalized?			17. Have any skin problems? (itching, rash, acne)
4. Ever had surgery?			18. Have Diabetes?
5. Have frequent headaches?			19. Have Asthma?
6. Ever been knocked unconscious?			20. Had mononucleosis in the past 12 months?
7. Ever had head surgery?			21. Had problems with diarrhea / constipation?
8. Wear glasses, contacts or protective eyewear?			22. Ever had an eating disorder?
9. Ever had frequent ear infections?			23. Ever pass out during or after exercise?
10. Ever been dizzy during or after exercise?			24. Ever had emotional difficulties for which Professional help was sought?
11. Ever had seizures?			25. Ever had back problems?
12. Ever been diagnosed with a heart murmur?			26. Ever had chest pain during exercise?
13. Ever had high blood pressure?			
14. Ever pass out during exercise?			

Please explain any "yes" answers noting the number of the question and any past medical treatment (if any)

Please describe any current physical, emotional, or mental health conditions requiring medication, treatment, or special restrictions, supervision, or consideration while at camp:

Does your child have any known allergies or dietary restrictions: (Please Explain?)

Please list any current medications, prescribed and over-the-counter, taken by your child. Please include dose and frequency.

My child (is) (is not) able to participate in an active camp program including the activities listed below.  
(Circle One)

Are there any restrictions at camp? YES \_\_\_\_\_ NO \_\_\_\_\_

Please list any camp activities (Other than Hockey or Hockey related) from which the camper should be exempted for health reasons.

(Please explain)

Your signature serves as evidence that the individual parent /guardian or medical personnel has supplied complete and accurate health information related to your child's participation in specific camp activities.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Please Print Your Name

\_\_\_\_\_  
Date

**CURRENT CAMPER IMMUNIZATION RECORD**

(This must be signed or stamped by a physician or medical personnel)

**Directions:**

By orders of New York State Department of Health all campers must submit a Current Medical History including Immunization Updates. It must be kept on file for every camper and updated annually before they will be permitted to attend The Rinx Summer Hockey School.

\*If for religious reasons your child has not been immunized, contact the camp for a legal waiver stating conditions in place for attendance.

**Please note:** Due to strict enforcement by the Nassau County Department of Health, if your child is dropped off at camp without a record of Current Immunizations on file in our medical office, we must call you to come pick up your child.

**Camper Name:** \_\_\_\_\_

Please give all dates of immunization for:

<u>Vaccine:</u>	<u>Dates: (MO/ YR)</u>					
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
HEPATITIS B	_____	_____	_____			
VARICELLA (chicken pox)	_____	_____				
HAEMOPHILUS INFLUENZA TYPE B	_____	_____	_____	_____		
Other _____	_____	_____	_____	_____	_____	_____

Which of the following has the participant had? (Please circle)
Measles
Chicken Pox
German measles
Mumps
Hepatitis A
Hepatitis B
Hepatitis C
TB Mantoux Test:
Date of last test _____
Results: (Circle one)
Positive      Negative

**SIGNATURE/STAMP OF PHYSICIAN OR MEDICAL PERSONNEL:** \_\_\_\_\_

**PRINTED:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Camp use only:**

**Date Received by office:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_