SUMMER HOCKEY SCHOOL
Phone: 631-232-3222 Fax: 631-232-3228

Name _____ Grade as of Sept. _____ Date _____

(Office use only - Group: _____)

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 Suffolk 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 May 23, 2024. Thank you for your cooperation.

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

PLEASE RETURN TO CAMP OFFICE PRIOR TO MAY 23, 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 _____ _____

(Parent / Guardian Signature)

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	
11. Ever had seizures?		Professional help was sought?	
12. Ever been diagnosed with a heart murmur?		25. Ever had back problems?	
13. Ever had high blood pressure?		26. Ever had chest pain during exercise?	
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 Hidden Pond Day Camp.
***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 Suffolk 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:

Vaccine:	Dates: (MO/ YR)					
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:*** _____