

Bishop Ford High School Camps

500 19th Street, Brooklyn, New York 11215 718-360-2500 FAX 718-360-2595

MEDICAL CERTIFICATE

Camper Information

Name: _____ Sports: _____
Address: _____
City, State, Zip _____ Phone: _____
Birthdate (M/D/YY): _____

Emergency Information

In case of accident or serious illness the school will contact the parents. If we are unable to reach you, please give the name of a physician we may call for instructions. Also list two relatives or neighbors who will assume temporary care of your child if you cannot be reached.

Parent(s) or Guardian(s)

Father: _____	Mother: _____
Occupation: _____	Occupation _____
Company: _____	Company _____
Business Address: _____	Business Address: _____
Business Phone: _____	Business Phone: _____
Physician's Name: _____	Phone: _____
Address: _____	
Relative / Neighbor: _____	Relative / Neighbor: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail if none of the above can be reached by phone. In the event that the school is unable to reach me, I **(give, refuse)** permission for any necessary treatment or surgery to be performed in the case of a serious emergency. (Cross out appropriate word)

Signature of Father

Signature of Mother

Health Insurance

Insurance Company: _____ Policy # _____
Camper's SS#: _____ Policy Holder's SS#: _____

Medical Information and History *(to be completed by Physician)*

Has anyone in your family under age 45 died suddenly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever had:		Serious illness or any illness for more than 10 days	Yes <input type="checkbox"/> No <input type="checkbox"/>
Concussion or been knocked out	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any operations or hospitalizations	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Easy bruising or bleeding tendency	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heat Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy, seizures or convulsions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Head or neck injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bee sting allergy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Very bad vision in one or both eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing loss or deafness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart trouble or murmurs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Perforated ear drum or "tubes" in ears	Yes <input type="checkbox"/> No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Draining ears	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cough lasting more than 3 weeks	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus problems or hay fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chest pain or faintness with exercise	Yes <input type="checkbox"/> No <input type="checkbox"/>
Braces or removable false teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any broken bones	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin infections	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dislocation or other serious problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	
Serious foot problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you wear glasses, contacts, other?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back injury or frequent backaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you take any medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ankle or knee injury or problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you smoke?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other joint problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever been told not to play any sport because of your health?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hernia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Boys: Any problems with testicles?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Do you have or have you had any orthopedic defects?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If "Yes" was answered to any of the above questions above, please provide explanation: _____

Physical Examination

A complete physical examination for all campers is recommended. Omission of the Maturation Index will not disqualify a student from participation.

Height _____	Weight _____	Pulse _____	Blood Pressure _____
Vision Uncorrected	L 20/____ R 20/____	Vision Corrected	L 20/____ R 20/____
	Normal Abnormal Comments		Normal Abnormal Comments
Skin	_____	Lungs, Chest	_____
Eyes	_____	Spine	_____
ENT	_____	Abdomen	_____
Mouth & Teeth	_____	Genitalia (Hernia)	_____
Neck	_____	<u>Extremities</u>	_____
Cardiovascular	_____	Orthopedic	_____
Allergies	_____	Neuromuscular	_____
Maturation Index	_____		
Other tests, if done (Lab, ECC, etc.)	_____		
Assessment: _____	Plan: _____	_____	

Special Conditions for Participation (e.g., pre-exercise medication or protective equipment, if any):

I have examined the camper named above, reviewed his/her health history and found that he/she is physically fit and able to participate in sports, except as noted above.

Physician's Signature

Date

Physician's Address

Physician's Phone

Physician's Stamp

Parental Permission for Participation in the Bishop Ford Summer Camp

I give permission for _____ to participate in all Athletic Programs.

Signature

Relationship

Date