



SETON HALL UNIVERSITY 2019 SUMMER CAMP HEALTH FACT SHEET

- PLEASE PRINT -

CAMPER'S NAME _____ BIRTH DATE _____

ADDRESS _____
Number & Street City State Zip

PARENT/GUARDIAN'S NAME _____ RELATIONSHIP _____

HOME PHONE _____ CELL/WORK PHONE _____

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN) _____

RELATIONSHIP _____ PHONE _____

INSURANCE CARRIER _____ POLICY OR GROUP NUMBER _____

WAIVER / RELEASE: I hereby agree to let my child participate in this camp. I understand that there are certain risks of injury inherent in the practice and play of these sports/activities, as well as in traveling and other related activities incidental to my participation, and am willing to assume these risks. I hereby certify that my child is fully capable of participating in the sports/activities, and that he/she is healthy and has no physical or mental disabilities or infirmities that would restrict full participation in this camp, except as included in writing in his/her application. In addition to giving full consent for my child's participation, I do hereby waive, release and hold harmless The Pirate Sports Camp, its officers, coaches, sponsors, partners, supervisors and representatives for any injury that may be suffered in my child in the normal course of participation in the sport and the activities incidental thereto, whether the result of negligence or any other cause. The law requires that parental permission be obtained for procedures on minors. This release allows for such procedures to be promptly carried out, and so that no unnecessary delays will occur with operative procedures. **HOWEVER, NO OPERATION WILL BE PERFORMED, EXCEPT IN AN EXTREME EMERGENCY, WITHOUT PARENTS BEING CONTACTED AND FULLY INFORMED.**

DATE: _____ **SIGNATURE:** _____ **RELATIONSHIP:** _____

PERSONAL HISTORY:

All medical information is strictly confidential. Please provide details of all positive answers under remarks.

	YES	NO		YES	NO
Allergy to any medications (specify medication & reaction under remarks)	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Serious reaction to insect bites or foods	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever, hives, season allergies	<input type="checkbox"/>	<input type="checkbox"/>	Joint injury or disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cycle disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur or any other disorder to the heart	<input type="checkbox"/>	<input type="checkbox"/>	Disabling loss of vision, hearing	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones or history of kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia; including Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
			Colitis, irritable bowl or Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS _____

PLEASE LIST ANY MEDICATIONS YOU USE ON A REGULAR BASIS (INCLUDE AMOUNT AND USAGE PER DAY)

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

IMMUNIZATION HISTORY (Please booster according to ACIP guidelines)

A. TETANUS-DIPHTHERIA month / day / year
 Completed primary series of tetanus-diphtheria immunizations..... / /

B. M.M.R. (MEASLES, MUMPS, RUBELLA) if given instead of individual immunizations
 1. Dose 1 - Immunized on or after first birthday..... / /
 2. Dose 2 – Immunized at five years or later..... / /

C. MEASLES
 1. Dose 1 - Immunized with live measles vaccine on or after the first birthday..... / /
 2. Dose 2 – Immunized at least one month after Dose 1 (Recommended by the State Department of Health, the ACHA, CDC, AAFP and AAP and required by SHU)..... / /

D. RUBELLA
 Immunized with vaccine on or after first birthday..... / /

E. MUMPS (check appropriate box)
 1. Had disease; confirmed by office record..... / /
 2. Immunized with vaccine on or after first birthday..... / /

F. POLIO (check appropriate box) Type of vaccine: Oral Inactivated E-IPV
 Complete primary series of polio immunization..... / /

G. TUBERCULOSIS PPD Applied (must be within past year) Positive Negative
 If PPD positive, please note chest x-ray date and results as well as INH dates under remarks below

Any history of reaction to food, serum, drugs, or medication? NO YES EXPLAIN

SEX AGE HEIGHT WEIGHT BP PULSE RESP

VISION: Uncorrected – Right 20/ Left 20/ ; With glasses/contacts - Right 20/ Left 20/

HEARING: Right Normal - YES NO ; Left Normal - YES NO Impairment

	SYSTEM	SATISFACTORY	UNSATISFACTORY	DESCRIBE ABNORMALITY
1	Skin, Lymphatics			
2	Eyes			
3	Ears			
4	Nose, Throat			
5	Neck, Thyroid			
6	Chest, Breasts, Lungs			
7	Heart Rate / Rhythm			
8	Heart Murmur (describe)			
9	Abdomen, Liver, Kidneys, Spleen			
10	Hernia			
11	Genitalia			
12	Pelvic (if indicated)			
13	Rectal (if indicated)			
14	Extremities, Back, Spine			
15	Joints			
16	Neurological			

The following abnormalities should be noted:

The applicant DOES DOES NOT have a history of emotional, psychological, or psychiatric disturbance

Applicant may participate in camp activities: Without restriction With the following restriction

Applicant should not participate in sports. Reason for limiting activity:

I find that the above named athlete is physically able to receive athletic training services from the Sports Medicine staff of Seton Hall University.

HEALTH CARE PROVIDER (Please Print) NAME PHONE

ADDRESS SIGNATURE