** ENSURE BOTH SIDES ARE COMPLETED BEFORE SUBMITTING TO CAMP ADMINISTRATION **

SETON HALL UNIVERSITY
2020 SUMMER CAMP HEALTH FACT SHEET

- PLEASE PRINT CLEARLY-

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 wiling 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
Allergy to any medications (specify medication & reaction under remarks)	☐	☐
Serious reaction to insect bites or foods	☐	☐
Hayfever, hives, season allergies	☐	☐
Hepatitis	☐	☐
Heart murmur or any other disorder to the heart	☐	☐
Thyroid or endocrine disorder	☐	☐
Kidney stones or history of kidney disease	☐	☐
Anemia; including Sickle Cell Anemia	☐	☐

	YES	NO
Seizure Disorder	☐	☐
Migraine headache	☐	☐
Joint injury or disease	☐	☐
Menstrual cycle disorder	☐	☐
Disabling loss of vision, hearing	☐	☐
High Blood pressure	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
Colitis, irritable bowl or Crohn's disease	☐	☐

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 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_____