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