**Bishop Ford High School Camps**

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

**Medical Certificate**

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

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| **Parental Permission for Participation in the Bishop Ford Summer Camp** |
| I give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in all Athletic Programs. |
|  |  |  |
| Signature | Relationship | Date |

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