Ultimate Sports Camp Medical Form

2309 65th Street * Brooklyn, NY 11204 * Fax: (347)-275-9819

NAME: LAST, FIRST	DATE OF BIRTH	GRADE (SEP. 2014)

PHYSICAL EXAMINATION TO BE FILLED OUT BY LICENSED PHYSICIAN

I examined this individual on _____. In my opinion, the above camper (is/is not) able to participate in all camp programs.
I give the nurse at Ultimate Sports Camp permission to administer any over the counter medications (as per package instructions) that the parents have approved. (Yes/No)

Height _____ Weight _____ BP _____

Vaccine	**Mon/Year**	**Mon/Year**	**Mon/Year**	**Mon/Year**	**Mon/Year**	**Mon/Year**
DPR						
TD (Tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
Heamophilus influenza B						
Hepatitis A						
Hepatitis B						
Varicella (Chicken Pox)						
Pneumococconal (PCV)						
Meningococcal Meningitis (MCV4)						
TB/Mantoux Test (Positive/Negative)						

Does the camper have any of the following:

- ☐ Asthma
- ☐ Convulsions
- ☐ Heart trouble
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Allergies (If yes, please list _____)
- ☐ Contact lenses
- ☐ Other: _____

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Emergency Contact Name	**Phone Number**	**Relationship**
1.		
2.		
3.		

Name of Physician:	Phone:
Signature of Physician:	Date:

Additional Comments: