MAILING ADDRESS
Hofstra University Summer Camps
250 Hofstra University
Hempstead, NY 11549-2500
Phone: 516-463-2267
Fax: 516-463-6114

HOFSTRA UNIVERSITY
SUMMER CAMPS

Date_____

EMPLOYEE MEDICAL HISTORY FORM

To be filled in by parents/guardians of minors or by adult campers/staff members themselves.

Name_____ **Birth Date** ____/ ____/_____ **Sex**_____ **Age** _____
Last First M.I.

Parent or Guardian (or Spouse) _____Phone (_____)_____

Home Address _____
Street and Number City State ZIP Code

Business Address _____Phone (_____)_____
Street and Number City State ZIP Code

Second Parent or Guardian: _____

Home Address _____Phone (_____)_____
Street and Number City State ZIP Code

If not available in an emergency, notify: _____Phone (_____)_____

Address _____
Street and Number City State ZIP Code

Health History:
(Check and give approximate dates.)

- ☐ Frequent Ear Infections _____
- ☐ Heart Defect/Disease _____
- ☐ Convulsions/Epilepsy _____
- ☐ Diabetes _____
- ☐ Bleeding/Clotting Disorder _____
- ☐ Hypertension _____
- ☐ Psychiatric Treatment _____
- ☐ Mononucleosis _____
- ☐ Asthma _____
- ☐ Allergies _____

Family Medical History

- ☐ Premature death related to cardiovascular disease
- ☐ Disability from cardiovascular disease at age <50 years
- ☐ Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan syndrome, arrhythmias, channelopathy, (ekg, long QT)

Has this camper ever required any psychiatric counseling or hospitalization? _____

_____

Operations or serious injuries *(dates)*:_____

_____

Disability or chronic or recurring illness:_____

_____

Any specific activities to be encouraged or limited by physician's advice:

_____

Other diseases or details of above: _____

_____

_____

_____

Name of family physician:_____Phone_____

Do you carry family medical/hospital insurance?_____

If so, indicate carrier:_____

Policy or group no.:_____

Suggestions or health-related information for camp personnel:_____

_____

_____

_____

IMPORTANT — BOX A OR B MUST BE COMPLETED FOR EMPLOYEE'S ATTENDANCE.

A

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:
I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me and/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for off-campus trips.

Signature of parent or guardian or adult camper/staffer _____

B

I do not wish to give the camp permission to give emergency care if I cannot be reached.

Signature _____

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EMPLOYEE PHYSICAL EXAMINATION

Immunization history must be attached to this form.

(Please print clearly.)

Employee's Name _____ Birth Date___ /___ /_____
Last First Middle Initial

PHYSICAL CONDITION : **Date Examined:** _____

_____	_____	_____	_____	_____
Height (Ht.)	Weight	Blood Pressure	Urinalysys (VA)	Hemoblobin (Hg)

ALLERGIES (food, drugs, plants, insects, etc.) **:** _____

PHYSICAL EXAM: ❑ Heart murmur ❑ Physical stigmata of Marfan Syndrome ❑ Femoral vs. radial pulses to exclude aortic coarctation ❑ Brachial artery blood pressure

PERSONAL MEDICAL HISTORY: ❑ Exertional chest pain/discomfort ❑ Syncope/near syncope ❑ Prior recognition of a heart murmur ❑ Excessive, unexplained exertional dyspnea or fatigue ❑ Prior recognition of a heart murmur ❑ Elevated blood pressure

FAMILY MEDICAL HISTORY: ❑ Premature death related to cardiovascular disease ❑ Disability from cardovascular disease at age 50+ ❑ Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan syndrome, arrhythmias, channelopathy (eg, long QT)

The applicant is under the care of a physician for the following condition(s): _____

_____

_____

In my opinion the above condition(s) does____ /does not____ preclude his/her participation in an active camp program.

Current treatment *(include current medications)*: _____

_____

Explanation of any reported loss of consciousness, convulsion or concussion:

_____

_____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any treatment to be continued at camp: _____

ANY MEDICATION to be administered at camp? ❑ Yes ❑ No

Name of medication(s): _____

Dosage: amount(s) to be given _____

time(s) to be given _____

Side effects: to report _____

to expect _____

Diagnosis _____

Any medically prescribed dining plan or dietary restrictions _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child _____ receive the medication as prescribed on this form by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse or other assigned person will administer the medication.

_____
Signature (Parent/Guardian)

Address: _____

Telephone: Home_____ Work_____

Cell_____ Other_____ Date _____

ADDITIONAL INFORMATION:

Licensed Physician's Signature _____

Phone_____ Address _____

Date of form completion _____ by_____

Initial if completed by nurse or physician's assistant: _____

Physician's Stamp: