Camp Medical Form

Child's Name: _____ DOB: _____

Gender: ☐ Male ☐ Female

Contact information

Address: _____ City: _____ State: _____

Zip Code: _____ Phone number: _____

Cell phone number: _____ E-mail: _____

Parent's Name: _____

Emergency contacts

Primary contact: _____ Relation to camper: _____

Day phone: _____ Evening phone: _____

Secondary contact: _____ Relation to camper: _____

Day phone: _____ Evening phone: _____

Insurance policy

Policy holder's name: _____ DOB: _____

Relation to camper: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone number: _____

Insurance company: _____ Policy number: _____

Phone number: _____

Medical history

Does the camper have any of the following? If yes, please elaborate.

Drug allergies _____ Food allergies _____

Animal allergies _____ Special dietary needs _____

Asthma _____ Recurring headaches, dizziness, or seizures _____

Other health issues _____

Is the camper on any medications? _____

Will the camper require any specific treatment will participating in our program?

_____

Immunization

☐ Measles ☐ Mumps ☐ Rubella ☐ MMR ☐ Polio series complete

Last tetanus _____ Last medical check-up _____

Physician's information

Physician's name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone number: _____

I have examined the named camper and found him/her to be free from infectious and contagious diseases and qualified for full participation in camp.

Physician signature: _____ Date: _____

Print name: _____

Medical treatment consent: I give permission for my son/daughter to participate in the Youth Tennis Academy camp. I agree that my son/daughter will abide by YTA camp rules, and I realize that any breach of conduct may result in expulsion from camp without refund. I hereby agree to the payment schedule and refund policy. I authorize YTA or its authorized representatives, at its discretion, to place my son/daughter, in a case of emergency, at my own expense and without further consent, in a hospital for medical service and treatment, or if no hospital is not readily accessible, to place my child in the care of a licensed doctor for treatment. I agree not to leave my son/daughter on YTA premises while dropping him/her off without making sure that there is direct supervision by an authorized representative of YTA.

Parent/Guardian signature: _____ Date: _____

Print name: _____

Please mail forms to:
Andrey Spichkin, 221 Deady Ave Stoughton, MA 02072