PRIME TIME FOOTBALL SKILLS CAMP at BROOKWOOD CAMPS GLEN SPEY, NEW YORK 12737 (631) 321-1703

Long Island Office:
PO Box 475
Babylon, NY 11702
(631) 321-1703
Fax: (631) 587-1070

Executive Director:
Kenneth Fiedler
Camp Directors:
Jay Fiedler
Scott Fiedler

CAMPER MEDICAL FORM

TO BE COMPLETED BY PARENT:

Child's Name: ______________________________ Date of Birth: ____________________________

Address: ____ Telephone: Day: (____) ____________________

____ Evening: (____) ____________________

Cell: (____) ____________________

Pertinent Past Medical History:
____
____
____

Please Check all that apply

☐ Ear Infections
☐ Seizure Disorder
☐ Pneumonia
☐ Eyeglasses/Contacts
☐ Diabetes
☐ Headaches
☐ Heart Disease Defect
☐ Asthma
☐ Nose Bleeds

Special Medication (if any):

____

____

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parent(s) or guardian of campers. In the event I cannot be reached, I hereby give permission to the physician selected by Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

****Parent's Signature**: X______________________________________Date: _______________

TO BE COMPLETED BY PHYSICIAN:

History:

____

____

Allergies:

____

____

Immunization History:

	Diphtheria, Pertussis, Tetanus		Trivalent – Polio Vac.		Type	Date	Tests		
	Dose	Date	Dose	Date			Date	Type	Result
1					Measles			Hb. Electro	
2					Rubella			Hb/Hct	
3					Mumps			Lead	
4					Measles Mumps Rubella			Urine	
								Vision	R | L
								Hearing	R | L
								Tine	

Physical Exam:
Physical Exam Findings:

(Diagnosis): ____

A. If normal, please check ________ Height: __________ Weight: _________
B. Abnormal Findings: ____

____

Name of Physician (Please print or use rubber stamp): ______________________________________

Address:____

Telephone: (_____) ____________________

Physician's Signature: ________________________________ Date: _________________