AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Camper Name_____ Gender ___M ___F Date of birth _____
Address, City & State_____ Home Phone_____
Parent/Guardian Name:_____ Work Phone_____

Insurance Company_____ Policy/ID No._____
Name of Policy Holder_____ Group No._____

Note: A copy of your insurance card must be returned with this form.

Please list two additional contacts in case of emergency (other than parents)
Name, Phone, Relationship_____

Name, Phone, Relationship_____

Medical Authorization

I/We, being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint the staff of the SUNY New Paltz Summer Sports Camps, to act in my/our behalf in authorizing emergency medical, dental, surgical care and hospitalization for the above-named minor during the following period of Summer Sports Camp (please check appropriate camp):

_____ Hawks Sports Camp _____ Elite Swimming Camp _____ Varsity Girls Soccer Camp

_____ _____ _____ _____
Signature of Parent/Guardian Date Signature of Witness Date

PARTICIPANT MEDICAL INFORMATION

Immunization Information:

Please provide a copy of your child's current school immunization records or complete the section below.

DPT Series	Date 1	Date 2	Date 3	Booster
Polio OPV	Date	Booster	***Tetanus Booster***	Date
Measles Vaccine (live)	Date	***Mumps Vaccine (live)***	***Date***	
TB Test	Date	Result	***German Measles***	Date

Medical Information:

Date of last physical examination_____
Name of physician_____ Telephone No._____

Family History: (Please list all family diseases, i.e. Diabetes, Tuberculosis, Epilepsy)
_____

Personal History (Check the following diseases or conditions the child has had)

	Allergy Injections		Anemia		Bronchitis		Epilepsy
	Chicken pox		Chronic intestinal problem		Diabetes		Hives
	Congenital or heart problem		Diphtheria		Eczema		Hepatitis
	Emotional Disorder		Frequent Colds		Sore Throats		Hay Fever
	Infectious jaundice		Kidney Disease		Malaria		Malignancy
	Measles		Rubella (English/ Red)		Rubella		Mumps
	Mononucleosis		Orthopedic Problems		Otitis Media		Tonsillitis
	Hearing Impairment		Poliomyelitis		Pneumonia		Sinusitis
	Psychiatric Disease		Rheumatic Fever		Scarlet Fever		TB Contact
	Rheumatoid Arthritis		Seizure Disorder		Speech Defect		Tuberculosis
	Whooping Cough						

Severe injuries/operations and dates

_____

_____

Medical problems, drug or food allergies

_____

_____

Medications being taken at present

_____

I certify that the medical information included on this form is correct.

Signature: _____ Date: _____

SELF-MEDICATION RELEASE AUTHORIZATION

(This section must be completed for students who request permission to carry their own medications on campus)

_____ has been instructed in the proper use of the following
(Child's name)
medication procedures: _____

_____

_____ and _____
(physician's signature) (parent's signature)

request that _____ be permitted to carry the medication on his/her
(child's name)
person or to keep same in his/her room, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.
Dated: _____

Parent and Prescriber's Authorization for Administration at Camp

Authorization for Administration of Medication

A. To be completed by parent or guardian:

I request that my child _____ age _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp Medical Director or Head Athletic Trainer will administer the medication or an adult will supervise my child taking his/ her own medication.

Signature of parent/guardian _____ Date _____

Address _____ Telephone Home_____ Work _____

B. To be completed by licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Patient name _____ Date of birth _____
Diagnosis _____
Name of medication _____
Prescribed dosage, frequency and route of administration _____
_____
Time to be taken during camp hours _____
Duration of treatment _____
Possible side effects and adverse reactions (if any) _____
_____
Other recommendations _____

Name of Licensed Prescriber and Title (please print) _____
Prescriber's signature _____ _Date _____
Address and telephone _____

All sports camps forms must be received in our office *before the one week* prior to the beginning of camp. Please mail forms to:

Summer Sports Camp Office
Elting Gymnasium
SUNY New Paltz
1 Hawk Drive
New Paltz, New York 12561

Should you have questions, please call our office at (845) 257-3910.