The Skating Academy

HEALTH RECORDS & INFORMATION – Please complete all information and/or attach your physician's form

SKATER'S NAME: DOB: AGE:

GENDER: *Male* *Female* BLOOD PRESSURE: HEIGHT: WEIGHT:

DIAGNOSIS (AT PARENTS' DISCRETION):

IMMUNIZATION HISTORY– Please record the date (month and year) of basic immunizations and most recent booster doses

Vaccines	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DPT (Diphtheria, Pertussis, Tetanus)					
TD (Tetanus, Diphtheria)					
Tetanus					
Polio					
MMR (Measles, Mumps, Rubella)					
Hepatitis B					
Varicella (Chicken Pox)					
Hib (Haemophilus influenza)					
Tuberculin Test Results					
Lead Test Results					
Other					

HEALTH STATUS – Check if normal or give details

Eyes	Ears	Lungs	Genitalia
Vision	Hearing	Posture	Menstruation
Skin	Teeth	Musc/Skel	Hernia
Throat	Heart	CNS	Abdomen

KNOWN ALLERGIES AND TREATMENT

FOOD: MEDICATION:

ENVIRONMENT: INSECT:

Is the person currently under the care of a physician? Circle: *Yes* *No* If yes, why?_____
Current medications or treatment: _____
Recommend/Describe any limitations or restrictions on camp activities: _____
Medications to be taken/administered at camp: (including sunscreen, inhalers, or the like)
Name of Medication(s) _____

MEDICATION POLICY - Please list ALL prescription medication, and any OTC or nonprescription drugs, taken routinely

A sufficient supply of medication (enough to last the entire enrollment at camp) must be brought to the nurse. Please remember to keep the medication in the original, packaged container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. A Medical Authorization Form must be signed by the parent.
Additional health information: _____

I have examined this child herein described and it is my opinion that this child is able to engage in and participate in all camp activities, unless otherwise noted above. **(Date of examination must be within 24 months of start date of camp.)**

LICENSED PHYSICIAN'S SIGNATURE: DATE OF EXAMINATION:

PHYSICIAN LICENSE NUMBER: .

ADDRESS: TELEPHONE:

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