

**MERCER COUNTY COMMUNITY COLLEGE ---SUMMER SPORTS CAMPS
HEALTH HISTORY & MEDICAL AUTHORIZATION FOR ALL PERSONS UNDER AGE 18**

**This form must be completed with inoculation dates and returned with EACH camp application.
Note: A doctor's signature is NOT required.**

NAME OF STUDENT _____

Last	First	MI	DOB
Parent/Guardian #1 Name: _____	Daytime Phone: _____		
Parent/Guardian #2 Name: _____	Daytime Phone: _____		
Alt. Emergency Contact: _____	Daytime Phone: _____		
Family Physician: _____	Daytime Phone: _____		
2 nd Physician/Orthodontist: _____	Daytime Phone: _____		

PLEASE COMPLETE THE FOLLOWING:

1. Currently under physician's care for: _____
2. Current medications being taken: _____
3. Were you ever advised not to allow this child to play in any sports? _____ **YES*** _____ **NO**
4. List any malfunction or loss of an organ: _____
5. List any allergies including bee stings, peanuts, hives, asthma: _____
6. Will your child need medication at camp? _____ **YES*** _____ **NO**
If yes, please bring medication to the athletic office on the first day your child attends camp.
7. Has this child:

	YES*	NO
(a) had difficulty with sight?	_____	_____
(b) had difficulty with hearing?	_____	_____
(c) ever been unconscious after an injury?	_____	_____
(d) had a fracture or dislocation within the last three years?	_____	_____
(e) ever experienced high blood pressure?	_____	_____
(f) ever experienced chest pain/palpitations?	_____	_____
(g) had to stay in the hospital overnight within the last year?	_____	_____
(h) other _____		
8. Does this child have a history of:

(a) fainting with exercise?	_____	_____
(b) undue tiredness/fatigue?	_____	_____
(c) a family member having sudden unexplained death under the age of 40?	_____	_____

*** Please explain (attach extra pages if necessary)**

According to state law, all campers must be immunized or submit a statement from a physician that immunization is in progress.**

**IMPORTANT: Attach copy of Immunization
Record from Doctor's office.**

If an emergency illness or injury occurs, I (parent/guardian) hereby authorize Mercer County Community College to treat and/or send this person to a physician or hospital and authorize the necessary treatment. I also authorize the physician or hospital to release my child after treatment to a representative of Mercer County Community College. My child's medical insurance carrier is _____.
My hospital of choice is _____. All information on this form is complete, true and accurate to the best of my knowledge.

SIGNATURE OF PARENT/GUARDIAN _____ **Date** _____

****NOTE**

1. If there is a religious objection to immunization of a child, a written statement must be signed and submitted which states that the child is in good health and that you will assume full responsibility for his/her health while in camp.
2. If immunization is contraindicated for medical reasons, the parent or guardian shall submit to the camp a written statement signed by a licensed physician, indicating both the reason and length of the medical contraindication.