



- Camps Attending:** (Please mark camp and circle week)
- " Basketball Week of 6/29 7/27 8/3
  - " Cross Country Week of 7/27
  - " Soccer Week of 7/6 7/13 7/20
  - " Volleyball Week of 8/10
  - " Tennis Week of 6/29 7/6 7/13 7/20
  - " Junior Raptors Camp Week of 6/29 7/6 7/13 7/20 7/27 8/3

## PERSONAL INFORMATION & MEDICAL HISTORY

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at Camp \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Street address City State Zip

Gender: "Male "Female

Parent/guardian \_\_\_\_\_ Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Street address City State Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Second parent or guardian \_\_\_\_\_

Business Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Address \_\_\_\_\_  
Street address City State Zip

**Emergency contact (other than parent or guardian):**

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

**Insurance Information**

Is the participant covered by family medical/hospital insurance? " Yes " No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

**Health History**

**Department of Athletics** Annandale-on-Hudson, NY 12504-5000 **Phone** 845-758-7531 **Fax** 845-758-7647  
**E-mail** athletics@bard.edu **Website** www.bard.edu/athletics

The following information must be completed by the parent/guardian of the camper. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided, in writing, to the Camp Director upon participant's arrival at camp. Please provide complete, accurate information to ensure the camp is aware of your child's needs.

**ALLERGIES** List all known. Describe reaction and management of the reaction.

**Medication allergies (list)**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

**Food allergies (list)**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

**Other allergies (list)** please include insect stings, hay fever, asthma, animal dander, etc.

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

**MEDICATIONS BEING TAKEN**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

\*Daily/routine medications will only be administered by **Medical Staff** w/ completed Individualized Order Form.\*

**"This person takes NO medications on a routine basis.**

**"This person takes daily/routine medications as follows:**

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

**"This person has a current prescription for emergency medication (e.g., Epinephrine Pen - bee stings)**

Medication \_\_\_\_\_ Reason for taking \_\_\_\_\_

**A member of the Bard College Summer Sports Camps Staff or the Junior Raptors Camp will contact you prior to the start of camp to discuss and develop a plan of action regarding this medication.**

**PLEASE NOTE**

If your child must take any medication while at camp, either prescription or over the counter, the **Individualized Order Form** must be completed as directed. The form must be completed and signed by a physician, and be on file for children requiring medication as part of an established routine, or on an "as needed" or emergency basis.

**General Questions** (Please explain all "Yes" answers below.)

| Has/does the participant:                                     | Yes | No |   | Yes | No |
|---|-----|----|---|-----|----|
| 1. Had any recent injury, illness or infectious disease?..... | "   | "  | 17. Ever had problems with joints (e.g., knees, ankles)?..... | "   | "  |
| 2. Have a chronic or recurring illness/condition? ....        | "   | "  | 18. Have any skin problems (e.g., itching rash, acne)? .....  | "   | "  |
| 3. Ever been hospitalized? .....                              | "   | "  | 19. Have diabetes?.....                                       | "   | "  |
| 4. Ever had surgery? .....                                    | "   | "  | 20. Have asthma?.....   | "   | "  |
| 5. Have frequent headaches? .....                             | "   | "  | 21. Use an inhaler?.....                                      | "   | "  |
| 6. Ever had a head injury? .....                              | "   | "  | 22. Had problems with diarrhea/constipation?                  | "   | "  |
| 7. Ever been knocked unconscious? .....                       | "   | "  | 23. Had mononucleosis in the past 12 months?                  | "   | "  |
| 8. Wear glasses, contacts or protective eye wear? .....       | "   | "  | 24. Have an orthodontic appliance being brought to camp?..... | "   | "  |
| 9. Ever had frequent ear infections? .....                    | "   | "  | 25. Have an absence of a paired organ?.....                   | "   | "  |
| 10. Ever passed out during or after exercise? .....           | "   | "  |   |     |    |
| 11. Ever been dizzy during or after exercise? .....           | "   | "  |   |     |    |
| 12. Ever had seizures? .....                                  | "   | "  |   |     |    |
| 13. Ever had chest pain during or after exercise? .....       | "   | "  |   |     |    |
| 14. Ever had high blood pressure? .....                       | "   | "  |   |     |    |
| 15. Ever been diagnosed with a heart murmur? .....            | "   | "  |   |     |    |
| 16. Ever had back problems? .....                             | "   | "  |   |     |    |

Please explain any yes answers, noting the number of the questions.

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**Immunization**

**COMPLETE IMMUNIZATION RECORDS are required for camp attendance. A copy of your child's Immunization History from your pediatrician may be submitted in lieu of completing the immunization section below.**

|   |   |  |
|---|---|--|
| Which of the following has the participant had?<br>" Measles<br>" Chicken pox<br>" German measles<br>" Mumps<br>" Hepatitis A<br>" Hepatitis B<br>" Hepatitis C | Please provide all dates of immunization for:<br>Vaccine: | Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr |
|   | DTP   | _____                                      |
|   | TD (tetanus/diphtheria)                                   | _____                                      |
|   | Tetanus   | _____                                      |
|   | Polio   | _____                                      |
|   | MMR   | _____                                      |
|   | or Measles  | _____                                      |
|   | or Mumps  | _____                                      |
|   | or Rubella  | _____                                      |
| TB Mantoux Test   | Haemophilus influenza B                                   | _____                                      |
| Date of last test _____   | Hepatitis B   | _____                                      |
| Result: " Positive "Negative  | Varicella (chicken pox)                                   | _____                                      |

Is there any reason why this camper's activity at camp should be restricted in any way?

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# Important

## The following signatures are required for participation in the Bard College Summer Sports Camps and the Junior Raptors Camp

**Parent/Guardian Authorizations:** This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine healthcare and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of the Bard College Summer Sports Camps and / or the Junior Raptors Camp, or their designee, to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**Indemnification:** The undersigned parent/guardian of the registrant, for and in further consideration of the Bard College Summer Sports Camps' and / or the Junior Raptors Camp's accepting said registrant, hereby agrees to save and indemnify and keep harmless the said Bard College Summer Sports Camps and / or the Junior Raptors Camp, its' agents and sponsors against any and all liability, claims, judgments or demands arising as a result of any course of instruction or activity given the registrant by the Bard College Summer Sports Camps and / or the Junior Raptors Camp.

Signature of Parent/Guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

### Question or Concerns:

Kristen Hall  
Summer Camps Director  
Bard College  
P.O. Box 5000  
Annandale-on-Hudson, NY 12504-5000  
Phone: 845-758-7528 / Cell: 845-505-3990  
Email: hall@bard.edu