



AGC! Big Top & Little Top Summer Circus Day Camps
2018 Medical Form

Important: This form must be completed and signed by parent or guardian before the child may begin camp.
Mail to: AGC! - 279 South Broadway, Nyack, NY 10960.
In addition, YOU MUST ALSO SUBMIT your child's IMMUNIZATION SCHOOL HEALTH FORM with all immunization dates indicated.

Camper's Name: _____ Age: _____ Birthdate: _____ Sex: _____

Mother's Name: _____

Father's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell/Work Phone (Mother): _____

Cell/Work Phone (Father): _____

If parent/guardian not available in emergency please notify:

Name: _____ Phone: _____

Doctor's Name _____

Doctor's Emergency Contact Info: cell: _____ ofc: _____

Medical Insurance/Medicaid Number: _____

Immunization History: Please list date(s) for the following. In addition to our form, YOU MUST ALSO SUBMIT your child's IMMUNIZATION SCHOOL HEALTH FORM with all immunization dates indicated. If you choose to not immunize your child/ren, you must submit a letter from your doctor and/or the school indicating your exemption. This is a requirement by the Rockland County Dept. of Health.

Diphtheria _____ Mumps _____ Rubella _____
Measles _____ Poliomyelitis _____ Tetanus _____
Hepatitis B _____ Varicella (chicken pox) _____ Haemophilus influenza type b _____

Allergies or Sensitivity: Is the camper subject to any of the following conditions? (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Behavior Problem | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Bad Back | <input type="checkbox"/> Autism | <input type="checkbox"/> ADD-ADDH | <input type="checkbox"/> Peanuts/nuts of any kind |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Lactose Intolerant | <input type="checkbox"/> Gluten Intolerant | <input type="checkbox"/> Other (explain below) |

Does your child have any dietary restrictions? Please explain: _____

Operations or Serious Injuries (Dates): _____

Chronic or Recurring Issues/Illnesses _____

Other Issues _____

Has your child been diagnosed with a developmental disability? (please describe):

Is the Camper on medication? If so, what? _____

Parents Authorization

This health history form is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by the examining physician and me. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Signature _____ **Date** _____

(Must be signed by parent/guardian)