

For Office Use Only

Date ____/____/____

Paid \$ _____

Check # _____

2012

RUTGERS  ATHLETICS
(SCARLET KNIGHTS INDIVIDUAL SKILLS CAMP)
PERSONAL HEALTH AND MEDICAL RECORD
TO BE COMPLETED BY PARENT OR GUARDIAN
 (Need not be completed by physician)

Participant's Name _____ Date of Birth ____/____/____

Address _____ Age _____

City, State and Zip Code _____

In Emergency Notify:

1. Name _____ Relationship _____
 Address _____ Home Phone _____
 City & State _____ Other Phone _____
2. Name _____ Relationship _____
 Address _____ Home Phone _____
 City & State _____ Other Phone _____

Emergency Medical Information

Has or is subject to *(Check and give details)*

- Asthma Convulsions Heart Trouble
 Diabetes Fainting Spells High Blood Pressure
 Allergy or reaction to any toxin
 Contact Lenses
 Any other condition(s) that may require emergency or special care, medication, or knowledge.

Explain: **Recommendations:** (Explain and restrictions or limitations)

Immunizations:

Month/Year Given	Check if Has Had Needed	Vaccination	Disease	Check if Needed
Tetanus _____	<input type="checkbox"/>	Measles <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria _____	<input type="checkbox"/>	Mumps <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio _____	<input type="checkbox"/>	Rubella <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Whooping Cough <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Chicken Pox <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Date or most recent physical exam (month and year) _____

Do you have any current health problems? No Yes

Are you under medical care or taking any medication? No Yes

Has there been any surgery, injury, allergy or change in health status since last complete physical exam? No Yes (Explain any "yes" answer below)



Social History

Is there disease of (or past or present history of):

	No	Yes	Year	Details
Social Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Eyes, Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bridges	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, Bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urine Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bed-Wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia rupture	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, Limbs, Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Behavioral Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (Explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

BELOW INFORMATION MUST BE PROVIDED IN ORDER TO PARTICIPATE IN CLINIC ACTIVITIES

Health Insurance Information

Company Name: _____ Policy # _____
 Is this an HMO? Yes No Group # _____

Parent's Authorization

To the best of my knowledge, history is complete and correct. I know of no reason to restrict applicant's activity and give my permission for participation in all activities except as specifically noted herein. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize, secure, select treatment for, and to order injection, anesthesia or surgery for my child as named above.

 (Date)

 (Parent or Guardian)

 (Applicant's Signature
 if 18 years of age)