

# ***SUNYIT Summer Clinic Health Record***

Participation is prohibited without this completed form.

Clinic(s) Attending: \_\_\_\_\_ Session or Clinic Dates: \_\_\_\_\_  
(One form allows clinic participant to participate in multiple clinics, but list all clinics above.)

Camper's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_ boy \_\_\_ girl

Primary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact (Other): \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

## **Health History**

Asthma:	Yes___	No___	Diabetes:	Yes___	No___
Heart Problem:	Yes___	No___	Cancer:	Yes___	No___
Orthopedic Problems:	Yes___	No___	Depression:	Yes___	No___
Head Injury:	Yes___	No___	Dizziness:	Yes___	No___
Chest Pain:	Yes___	No___	Irregular Heartbeat:	Yes___	No___
Shortness of Breath:	Yes___	No___			

## **Allergies:**

Please list any allergies: \_\_\_\_\_

\_\_\_\_\_

## **Medications:**

Please list any current medications along with dosage: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Treatment Authorization

In the event of an injury or illness, I give permission for my child, \_\_\_\_\_ to be treated by a qualified athletics trainer, coach trained in first aid, CPR, AED, and/or emergency room staff at the local hospital. I consent to have SUNYIT or above service providers use and disclose my child's protected health information for treatment and health care purposes. Protected health information includes medical and demographic information collected and/or created by above service providers. I understand that I will be responsible for all charges for health services by off-campus providers.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_