Arcadia International Tennis Health Record and Release Form

Every student must have this health record filled out and brought to Tennis Lessons Program check-in. This form to be completed and signed by a physician before your child can participate in the Tennis Lessons **(PLEASE DO NOT MAIL AHEAD)**

Attending: Arcadia International Tennis

Name: _____

DOB: _____ Age: _____ Sex: _____

Parent/Guardian: _____

Address: _____ Phone (Home):_____ Phone (Cell):_____ Phone (Work):_____

Emergency Contact:_____ Address: _____ Phone (Home):_____ Phone (Cell):_____

Health History

Other: _____

Please Indicate Yes or No for over the counter medications that may be administered to your child if necessary due to injury and/or illness, according to the manufacturer's recommendations, by the Arcadia Tennis Athletic Trainer.

Ibuprofen: Yes___ No___ Tylenol: Yes___ No___ Sudafed: Yes___ No___ Mylanta: Yes___ No___

Medication:

Robitussin DM: Yes___ No___ Benadryl: Yes___ No____

Pepto Bismol: Yes___ No___ Antibiotic ointment Yes___ No___

Asthma: Yes/No

Diabetes: Yes/No

Heart Problem: Yes/No

Mono: Yes/No

Cancer: Yes/No

Ear Infection: Yes/No

Please explain all "yes" answers_____

Hydrocortisone Cream 1% Yes____ No____

Immunization History (Please List Dates)

Copy of Immunization Record preferable

DPT_____ Booster_____

Polio OPV (Sabin) _____ Booster_____ Measles/Mumps/Rubella (MMR) #1_____ #2_____ Meningitis_____

See form, Td_____

Tuberculin Test _____ Results_____

Hepatitis B #1_____ #2_____ #3_____

Varicella _____

HIB #1_____ #2_____ #3_____ Restrictions/limitations for camper while at camp? Yes/No

If yes, please explain: _____ _____

Parent's Authorization

My child has had a recent physical on _____ and may participate in all activities at Arcadia International Tennis, Inc. I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release, staff, camp management and sponsors from any liability for any injury or illness incurred while at camp.

I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during this time.

Parent Signature_____ Date_____

I understand Arcadia Tennis retains the right to use for publicity and advertising purposes, photographs of students.

Parent/Guardian Signature Date _____

Note All medication will be checked and kept by the trainer. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The prescriber's authorization form must accompany all medication and requires the physician's signature.

Loss of Limb: Yes/No Orthopedic Problem: Yes/No Depression: Yes/No

Head Injury: Yes/No Migraine: Yes/No Tuberculosis: Yes/No

Other serious illness or injury: _____

List all current medications (Prescription, "over the counter" and herbal) _____

_____ _____

_____

Health Insurance Provider: _____ Policy/ID Number_____ Policy Holder's Name & DOB_____ Insurance Provider Contact Phone_____ Mailing address_____ Please include a photocopy of your Health Insurance card for our records.

Physician's Name: _____ Physician's Signature: _____ (Only needed in: MA, CT, NY, RI)

Address: _____ Phone: _____

Allergies

Aspirin: Yes____ No_____

Penicillin: Yes____ No_____

Sulfa: Yes____ No_____

Bee Stings: Yes____ No____

If yes, does he/she carry an Epi Pen: Yes: ____ No____ Food Allergies,

Please list: _____ _____