Baton Twirling Network, Inc.
14 Bond Street
Suite 395
Great Neck, NY 11021

MEDICAL HEALTH FORM

This does NOT need to be completed by a physician but MUST be filled in and submitted.

HEALTH RECORD OF:____Date of Birth:___________________
(Surname) (First Name)

Permanent Address:____Phone:(_____)__________________
(# and Street) (City) (State) (Zip)

Name of Insurance Company:______________________ Address:____

ID#:____ Group #:_____________________________

Important!! We must have a copy of the front & back of the Health Insurance Card for your child's file.

Health History:	**Date**	**Allergies**	**Yes/No**	**Tendency to:**	**Yes/No**
Chicken Pox	________	Penicillin	________	Bed Wetting	________
Ear Infections	________	Asthma	________	Fainting	________
Gastrointestinal Problems	________	Eczema	________	Hives	________
Kidney Problems	________	Hay Fever	________	Sleep Walking	________
Mumps	________	Poison Ivy	________	Other	________
Mononucleosis	________	Insect Bites	________		
Frequent Stomach Aches	________				
Recurrent Strep Throat	________				
Other	________				

Operations and Serious injuries with dates:____

X-rays within the last 5 years with dates & reasons:____

Chronic or Recurring illness:____

Tendency or Susceptibility to:____

Emotional or Physical Disabilities:____

Has your child ever been diagnosed/treated for ADD or ADHD?__________________________________

Has you child ever taken Ritalin, Dexedrin, Cylert or any other stimulants?_______________________

Comments or suggestions from parents:____

Important: Please notify the camp if this camper was exposed to any communicable disease(s) during 3 weeks prior to the start of camp or had a recent injury. **Camp requires that neither the physician nor the parent withhold the use of any medications for the summer that is in use by the child during the balance of the year without proper notification to the directors.**

PARENT'S AUTHORIZATION: "This health history is correct to the best of my knowledge and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. In the event I cannot be reached by phone in an EMERGENCY, I hereby give permission to the physicians selected by the camp directors to secure proper treatment for, and/or hospitalize and/or to order injection, sedation, anesthesia, X-ray, or surgery for my child as named above.

Date:____________________________ Signature:____
(Parent/Guardian)

If I am not available in an emergency, please notify:

Name:____Relationship:________________Phone:(____)___________________

Name:____Relationship:________________Phone:(____)___________________