

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

## MEDICAL HEALTH FORM

*This side to be completed by parent and reviewed with physician at time of examination. Exam should be no earlier than March 1.*

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.*

<u>Health History:</u>	<u>Date</u>	<u>Allergies</u>	<u>Yes/No</u>	<u>Tendency to:</u>	<u>Yes/No</u>
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 your 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: (\_\_\_\_) \_\_\_\_\_