PRIME TIME FOOTBALL TEAM CAMP & FLAG TOURNAMENT
at BROOKWOOD CAMPS
GLEN SPEY, NEW YORK 12737
(631) 321-1703

Long Island Office:
PO Box 475
Babylon, NY 11702
(631) 321-1703
Fax: (631) 587-1070

Camp Directors:
Jay Fiedler
Scott Fiedler
Tournament Directors:
Mike Tepper
Jeremy Beamon

CAMPER MEDICAL FORM

TO BE COMPLETED BY PARENT:

Child's Name: _____ Date of Birth: _____

Address: _____ Telephone: Day: (____) _____

_____ Evening: (____) _____

Cell: (____) _____

Pertinent Past Medical History:

Please Check all that apply

_____
_____
_____

- ☐ Ear Infections
- ☐ Seizure Disorder
- ☐ Pneumonia
- ☐ Eyeglasses/Contacts
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Disease Defect
- ☐ Asthma
- ☐ Nose Bleeds

Special Medication (if any):

_____
_____

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parent(s) or guardian of campers. In the event I cannot be reached, I hereby give permission to the physician selected by Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

****Parent's Signature**: X_____Date: _____

TO BE COMPLETED BY PHYSICIAN:

History:

_____
_____

Allergies:

_____
_____

Immunization History:

	Diphtheria, Pertussis, Tetanus		Trivalent – Polio Vac.		Type	Date	Tests		
	Dose	Date	Dose	Date			Date	Type	Result
1					Measles			Hb. Electro	
2					Rubella			Hb/Hct	
3					Mumps			Lead	
4					Measles Mumps Rubella			Urine	
								Vision	R | L
								Hearing	R | L
								Tine	

Physical Exam:

Physical Exam Findings:

(Diagnosis): _____

A. If normal, please check _____ Height: _____ Weight: _____
B. Abnormal Findings: _____
_____

Name of Physician (Please print or use rubber stamp): _____

Address:_____

Telephone: (_____) _____

Physician's Signature: _____ Date: _____