

## TERMS OF AGREEMENT – Far Brook School



By registering with Fundamentals Sports Camp, I agree to the following:

- All camp fees will be due by the first day of the camp week in which I have enrolled my child. A \$50 non-refundable registration fee is included in the cost of camp enrollment. If I cancel my registration by June 1st, I will receive a refund or a camp credit, minus the \$50 registration fee. If I register after June 1st, or cancel my registration after June 1st, no refund or credit can be issued.
- **All necessary signed forms and medical forms will be returned to Fundamentals by the first day of the camp week in which I have enrolled my child. My child will not be allowed at camp without these forms completed and signed (there are no exceptions).**
- I hereby authorize the officials of Fundamentals Sports Camp to render any treatment he/she deems necessary in the event of the emergency.
- I hereby give permission for photographs and video to be taken of my child and used for promotional purposes.
- If my child's conduct or influence is harmful to the best interests of Fundamentals Sports Camp, my child may be dismissed at the sole discretion of the Director with no refund or reduction in fees.
- I hereby give permission for my child to participate in Fundamentals Sports Camp on the campus of Far Brook School. I understand that Far Brook School has no involvement in the operation of this camp and hereby release Far Brook School and any of its employees or agents from any claims on my behalf or my child's behalf which may arise as a result of my child's participation in the camp.
- I understand there are certain risks inherent in the participation in sports, and I am willing to assume these risks. I hereby certify that my child is in excellent health and has been cleared by a physician within the past year to participate in strenuous sports activities. My child may participate in the following sports at camp: basketball, baseball, dodgeball, field hockey, flag football, golf, kickball, lacrosse, soccer, softball, summer Olympic sports, and Ultimate Frisbee.
- In addition to giving full consent for my child's participation, I do hereby waive, release and hold harmless Fundamentals Sports Camp, Inc., its officers, coaches, and employees for any injury that may be suffered by my child in the normal course of the participation of the sports camp and the activities incidental thereto, whether the result of negligence or any other cause.
- If I have any concerns or conflicts with these terms of agreement, I must submit them in writing to the Director of Fundamentals Sports Camp before my child participates in camp.

Child Name \_\_\_\_\_

Parent or Guardian Printed Name \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

This form can be opened with a PDF editing program (such as DocHub in Google Docs or Gmail) in order to complete it and sign it electronically.

This form can also be saved on a personal computer and edited for siblings or future camp seasons.

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

**To Parent(s)/Guardian(s): We highly recommend using a PDF editing program (such as DocHub through Google Docs or Gmail), complete and sign this form (and save it for siblings or future camp seasons) and return it in one of three ways:**

- a) scan and submit to the registration website: <https://campself.active.com/FundamentalsSportsCamp>
- b) scan and email to: [team@funsportscamp.com](mailto:team@funsportscamp.com)
- c) bring forms on the first day of camp

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Allergies:**  No known allergies.  This camper is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs. *(Please describe below.)*

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.  
*(Please describe below.)*

**Participation:**  My child has been examined within the past year by a licensed physician, is in good physical condition, and is able to participate in an active sports program.

### Medical Insurance Information:

This camper is covered by family medical/hospital insurance  Yes  No

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_

Insurance Company Phone Number (\_\_\_\_\_) \_\_\_\_\_

### Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_  
Date: \_\_\_\_\_ to Camper: \_\_\_\_\_

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Camper Name: \_\_\_\_\_  
 First Middle Last

Birth Date: \_\_\_\_\_  
 Month/Day/Year

**Immunization History:** Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: \_\_\_\_\_  Negative  Positive

**If your camper has not been fully immunized, please sign the following statement:**

**I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.

This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.

**Cross out those the camper should not be given.**

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE)	Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine	Guaifenesin cough syrup (Robitussin)
Diphenhydramine antihistamine/allergy medicine (Benadryl)	Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray	Generic cough drops
Ivarest	Antibiotic cream
Calamine lotion	Aloe
Laxatives for constipation (Ex-Lax)	Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

## **General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 12. Passed out/had chest pain during exercise? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No             | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No              | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | 15. Have problems with falling asleep/sleepwalking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                 | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 10. Wear glasses, contacts, or protective eyewear? ... <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**Please explain "Yes" answers in the space below**, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

## **Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
4. Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

**Please explain "Yes" answers in the space below**, noting the number of the questions. The camp may contact you for additional information.

## **Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in an active sports camp program. **Attach additional information if needed.**

**Parents/Guardians: Keep a copy for your records.**