



sports clubs for kids | camp 2020

Medical Information

Child's Name: _____

Child's Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Child's Dentist's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please answer the following questions:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do we have permission to administer minor first aide to your child if necessary? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do we have permission to seek medical attention for your child in case of emergency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do we have permission to have your child transported to a hospital in the case of an emergency? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, hospital preference _____

Personal Information:

In an attempt to better serve your child during camp, please list any additional needs they may have:

Allergies: (please list all known and describe reaction and management of reaction)

Medication allergy: _____

Food allergy: _____

Other allergies (please include insect stings, hayfever, asthma, animals, etc.) or any special medical issues we should be aware of: _____

Any specific activities that should be restricted?: _____

Please list any and all accommodations needed to perform physical activity (including alternatives): _____

Medications Being Taken: (Please list all medications, including non-prescription drugs, taken routinely.)

- This camper does not take any medications.
- This camper takes medication. If so, please fill in medications below (please note: we do not administer medications).

Medication 1: _____ Dosage: _____ Specific Time Taken: _____

Reason for taking medication: _____

Medication 2: _____ Dosage: _____ Specific Time Taken: _____

Reason for taking medication: _____

Physical/Immunizations History: (This section should be completed and signed by your child's physician. You may attach a doctor's printout.)

Measles: _____ Mumps: _____ Rubella: _____ or MMR (combined): _____

Tetanus (DPT or TT or TD): _____ OPV (Polio): _____ Hepatitis B: _____

Date of last Physical (within one year): _____

Physician's Signature: _____ Date: _____

Parent/Guardian Authorization: This health history medical information is correct and complete to the best of my knowledge, and the camper listed on this form has permission to engage in all camp activities, unless otherwise noted. Also, in the event of an injury or illness, every effort will be made to contact parent or guardian, prior to seeking treatment. By signing below, I give Town Sports International permission to seek emergency treatment in life-threatening situations before contacting me. By signing below, I also represent that the camper listed on this form is able to perform physical exercise and/or activity with or without accommodation and that any and all accommodations (including alternatives) are listed above.

Parent/Guardian's Signature: _____ Date: _____

NYSC | BSC | WSC | PSC

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EpiPen Consent and Release Form

EPIPEN CONSENT & RELEASE: I, THE UNDERSIGNED, hereby request and authorize the employees, contractors and agents ("Personnel") of Town Sports International, LLC, its parent, subsidiaries, and affiliates ("TSI") to administer auto-injectable epinephrine ("EpiPen") at such Personnel's discretion to my child for the following condition: _____.

In giving such authorization, I understand that neither the Personnel nor TSI shall not incur any liability and shall be held harmless from any claims for any injury arising from or as a result of the administration of, or failure to administer, the EpiPen other than those arising from such Personnel's or TSI's intentional misconduct. I further understand that I shall be responsible for providing an EpiPen to TSI and maintaining it as appropriate.

CUSTODIAL PARENT(S) and GUARDIAN(S)

Signature: _____

Name: _____

Title: _____

Date: _____