



NEW YORK FENCING ACADEMY INTERNATIONAL SUMMER CAMP

PHYSICAL EXAMINATION: PHYSICIAN FORM

To be completed and signed by Physician to provide a health record with pertinent information that will help to serve the needs of this camper while attending the New York Fencing Academy Summer Camp:

CAMPER'S NAME: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

IMMUNIZATION HISTORY

DTaP, DTP or TD Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Polio Date \_\_\_\_\_
Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ MMR Date \_\_\_\_\_ Date \_\_\_\_\_ Hemophilus
Influenzae type B Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Hepatitis B Date \_\_\_\_\_ Date \_\_\_\_\_
Date \_\_\_\_\_ Varicella Date \_\_\_\_\_ Date \_\_\_\_\_ Hepatitis A Date \_\_\_\_\_ Date \_\_\_\_\_
Other \_\_\_\_\_

MEDICAL EXAMINATION – To be filled out by licensed physician Examination is acceptable when performed no more than 12 months prior to the end of camp. Code: S = Satisfactory X= Not satisfactory (Explain) O= Not Examined

General Appearance \_\_\_\_\_
Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hgb. Test (Date) \_\_\_\_\_ Urinalysis (Date) \_\_\_\_\_
Posture & Spine \_\_\_\_\_ Throat – tonsils \_\_\_\_\_ Eyes \_\_\_\_\_
Vision \_\_\_\_\_ w/Glasses \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_ Ears \_\_\_\_\_
Hearing \_\_\_\_\_ Feet \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_ Nose \_\_\_\_\_
Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_
Genitalia \_\_\_\_\_
Neurological findings \_\_\_\_\_
Describe Abnormal Findings and /or Handicapping \_\_\_\_\_
Allergies: (Please specify) \_\_\_\_\_

Recommendations and restrictions while in camp.

Special Diet \_\_\_\_\_
Special medicine by name \_\_\_\_\_
Is parent/guardian sending special medicine? \_\_\_\_\_
Activity Restrictions \_\_\_\_\_
General Appraisal \_\_\_\_\_

I have examined the person herein described. reviewed his/her health history and it is my opinion that he/she is physically able to engage in New York Fencing Academy Summer Camp activities, except as noted above.

Examining Physician (Signature) \_\_\_\_\_

Physician's Name (Please Print) \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Date of Exam \_\_\_\_\_



**NEW YORK FENCING ACADEMY INTERNATIONAL SUMMER CAMP**  
**ALLERGY EMERGENCY TREATMENT AUTHORIZATION FORM**

**To be completed and signed by Parent/Guardian** to authorize emergency treatment for KNOWN Life Threatening Allergies:

Camper's Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Allergic to: \_\_\_\_\_

**Symptoms Give Medication checked "X"\***

- Mouth: Itching, tingling, or swelling of lips, tongue, mouth ( ) Benadryl ( ) EpiPen
- Skin: Hives, swelling on face or extremities, itchy rash ( ) Benadryl ( ) EpiPen
- Gut: Nausea, abdominal cramps, vomiting, diarrhea ( ) Benadryl ( ) EpiPen
- Throat: Tightening of throat, hoarseness, hacking cough ( ) Benadryl ( ) EpiPen
- Lung: Shortness of breath, repetitive coughing, wheezing ( ) Benadryl ( ) EpiPen
- Heart: Thready pulse, passing out, fainting, pale, blueness ( ) Benadryl ( ) EpiPen

If a food allergen has been ingested, but no symptoms ( ) Benadryl ( ) EpiPen

If a reaction is progressing (several of the above areas affected) ( ) Benadryl ( ) EpiPen

Medication Doses: Antihistamine (liquid diphenhydramine, Benadryl): Give \_\_\_\_\_ Teaspoon(s), \_\_\_\_\_ cc ( \_\_\_\_\_ mg) by mouth. Epinephrine EpiPen [EpiPen \_\_\_\_\_ ( \_\_\_\_\_ mg)] injected once into upper outer thigh.

Epinephrine injection may need to be repeated if the child's symptoms persist or get worse. Call 911 (or Ambulance service and phone number: \_\_\_\_\_) State that the child had a severe allergic reaction, and additional epinephrine does may be needed.

**Additional contact information:**

Allergist Name \_\_\_\_\_ Phone \_\_\_\_\_

Pediatrician Name \_\_\_\_\_ Phone \_\_\_\_\_

**Parent Name (other contacts) and Contact Numbers:**

Name \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Name \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Other allergies, medication allergies, medical conditions \_\_\_\_\_ Approximate weight \_\_\_\_\_ lbs

**DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED!**

\_\_\_\_\_  
Parent Signature Date



**NEW YORK FENCING ACADEMY INTERNATIONAL SUMMER CAMP**

**AUTHORIZATION TO ADMINISTER MEDICATION TO CAMPER - Part 1 of 2**

**To be completed and signed by Parent/Guardian and reviewed by Camp Nurse** - part 1 of 2:

Name of Camper: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_  
Age of Camper: \_\_\_\_\_ Sex of Camper: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
Food/Drug Allergies: \_\_\_\_\_  
Business Tel: \_\_\_\_\_ Emergency Tel: \_\_\_\_\_

Diagnosis (relevant to administration of medication) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Licensed Prescriber: \_\_\_\_\_  
Business Telephone: \_\_\_\_\_  
Emergency Telephone: \_\_\_\_\_

**Prescription Medication (one per form). Please see other side for over the counter meds:**

Name of Medication: \_\_\_\_\_  
Reason for taking Medication: \_\_\_\_\_  
Dose to be given at camp: \_\_\_\_\_  
Route of Administration: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_  
Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_  
Expiration of Medications Received: \_\_\_\_\_  
Special Storage Requirements: \_\_\_\_\_  
Specific Directions (e.g., on empty stomach/with water): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific Precautions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_  
\_\_\_\_\_

Other medications (to be sure no drug interactions): \_\_\_\_\_  
\_\_\_\_\_

I hereby authorize New York Fencing Academy Summer Camp to administer, to my child,  
\_\_\_\_\_ the medication listed above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Received by (signature): \_\_\_\_\_ Date: \_\_\_\_\_



**NEW YORK FENCING ACADEMY INTERNATIONAL SUMMER CAMP**

**AUTHORIZATION TO ADMINISTER MEDICATION TO CAMPER - Part 2 of 2**

**To be completed and signed by Parent/Guardian and reviewed by Camp Nurse - part 2 of 2:**

**Over-the-counter medications:**

Check the med and sign below if you would like to give camp nurses/health supervisors permission to administer any of the below medications on an as needed basis at their discretion. The dosage will be according to guidelines listed on the container.

Acetaminophen (Tylenol) for headaches, muscle aches, or fever     Y         N    

Ibuprophen (Advil/Motrin) for i.e. headaches, muscle aches, fever, menstrual cramps     Y         N    

Benadryl (only in case of hives/serious allergic reactions)     Y         N    

Other \_\_\_\_\_

I hereby authorize New York Fencing Academy Summer Camp to administer the medications circled Y above, to my child,

\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

**Please return completed and signed Medical Forms (4 pages) no later than 7/18.  
A copy of your health insurance card (both sides) is also required in order to attend camp.**

**Mail: New York Fencing Academy  
2896 W 12<sup>th</sup> Street  
Brooklyn, NY 11224**

**Email: [info.nyfa@gmail.com](mailto:info.nyfa@gmail.com)  
Phone: (718) 996-0426  
Website: [www.fencyfa.com](http://www.fencyfa.com)**