



THE STATE UNIVERSITY OF NEW YORK

Potsdam

Camp Name: _____

SUNY Potsdam Summer Youth Day Programs

Health History Report

(to be completed by a parent or guardian)

PLEASE PRINT

Participant's Name: _____ Sex: ___ Male ___ Female
Last First MI

Home Address: _____ Date of Birth: _____
Street

_____ City State Zip Code

Name of Parent(s)/Guardian(s): _____
Last First MI

Home Phone: () _____ - _____ Cellular: () _____ - _____

Work Phone: () _____ - _____

Emergency Notification: You must specify a person to be notified if the above parents/guardians are unavailable. This must be a person not listed above or residing at the same residence.

Name: _____ Relationship: _____

Phone: Home () _____ - _____ Work () _____ - _____ Cellular () _____ - _____

Health History

Please list any physical limitations or chronic conditions, such as asthma, epilepsy, diabetes, broken bones, etc:

Please list any known allergies:

Please list any additional information the camp staff should know:

Parent / Guardian Waiver

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed program activities, except as noted by me. We do hereby waive, release, and forever discharge said organization, its staff, officers, agents, representatives, employees, and their successors and assign from any and all claims for damages occurring during the participant's stay at camp, his/her participation in activities arising from traveling to or from camp, whether said accident, injury, or loss is due to negligence or not. I hereby give my permission for routine first aid at SUNY Potsdam and for routine emergency medical treatment at Canton-Potsdam Hospital. I authorize the use/disclosure of the camper's individual health information to Canton-Potsdam Hospital and any other facility which is needed in the event of an emergency.

Date: _____ Signature: _____

Health Insurance: Please provide specific insurance information.

Insurance Co. Name: _____ ID Number: _____

Subscriber's Name: _____ Camper's relationship to subscriber: _____

Group Number: _____ Please attach a copy of family prescription / insurance card if applicable.