Joe Namath/John Dockery Instructional Football Camp Fitness Report

Camper's Last Name **First Name** **Middle Initial** **Date of Birth**

Name of Parent (Guardian) **Address**

Home Phone **Business Phone**

Name of Physician **Phone** **Name of Dentist** **Phone**

Does camper have, or has he had: (If yes, please describe and specify dates)

Physical, Social or Mental Handicap -

Chronic or Prolonged Illness -

Other Illnesses (e.g. hepatitis, rheumatic fever, mononucleosis) -

Kidney Infection, Meningitis -

Asthma -

Allergy (food, insect, pollen, contact, drug, other) -

Convulsions, Fainting, Diabetes -

Fractures, Sprains, Dislocations -

Serious Injuries, Concussions -

Operations/Hospitalization -

Does the camper take medicine regularly? _____ Name of Medicine(s): _____

Latest Tetanus Shot Date: _____

Has camper had: Measles ( ), 3 Day Measles ( ), Mumps ( ), Chickenpox ( ), Whooping Cough ( )

Has camper had immunizations: Diphtheria ( ), Tetanus ( ), Smallpox ( ), Pollie ( ), Other:

TRIP PERMISSION SLIP: I hereby give the Namath/Dockery Football Camp permission to take my son on local camp trips.

In the event of an emergency, sickness, injury or accident, I hereby authorize the camp director or his designee to authorize medical treatment for my son.

Each Individual is required to have basic medical coverage. The camp does carry an excess medical insurance policy.

_____ _____

Date Parent or Guardian Signature - Authorization

In case of emergency contact: NAME _____ PHONE _____

(and/or) NAME _____ PHONE _____

TO BE COMPLETED BY PHYSICIAN

(Parent should be present for exam) Date of Exam _____ Ht. _____ Wt. _____

Audiometer: Right Ear _____ Left Ear _____ **Vision:** Right Eye _____ Left Eye _____

	Normal	Abnormal	Describe Abnormality
Appearance, Nutrition, Development	( )	( )	
Mental	( )	( )	
Skin, Rashes, Lymphatic	( )	( )	
Chest, Lungs, Pulse	( )	( )	
Abdomen, Genitals	( )	( )	
Back, Extremities, Feet, Muscles	( )	( )	
Neurological, Posture, Gait	( )	( )	
Laboratory, X-rays (as indicated)	( )	( )	

Hb (hct) _____ Urinalysis _____

Tuberculin skin test Date: _____ Type: _____ Result (MM) _____

Referral - Ear _____ Eye _____ Dental _____ Other (specify) _____

Studies, Treatments, Medications Needed:

The above examined player is in good physical health and able to participate in a contact football program

Signature of Physician _____ Date _____