Camp NEW You @ MU
Physician Referral Form
Early Registration Deadline: May 1, 2010
Final Registration Deadline: June 1, 2010

*****This form must be completed and signed by both the referring physician and consenting parent/guardian and returned with camp registration materials*****

Name of Camper: _____
Last First Middle

Date of Birth____/____/____ Gender: Male/ Female Age: _____

Name of Parent/Guardian: _____ _____
Last First Middle

Home address: _____
Street and Number

_____
City State Zip

Home Phone Number: (____) _____-_____ Alternative Number: (____)_____-_____

Emergency Contacts In Case Parent/Guardian Unavailable:

1. Name / relation to camper _____ Phone (_____)_____-_____

2. Name / relation to camper _____ Phone (_____)_____-_____

Body Mass Index (BMI)

To be eligible, campers must have a BMI greater than or equal to the 85th percentile for age, gender and stature.

BMI Calculation: [weight in pounds/ (height in inches)^2]*703

Camper's Weight (lbs): _____ Camper's Height (in):_____

BMI: _____ BMI Percentile: _____

** To obtain the appropriate BMI percentile growth chart, please refer to :

http://www.cdc.gov/growthcharts/

or call 1-304-696-3672 and we will calculate it for you.

Health History

Please Check all that Apply and provide explanation if needed:

Asthma:	_____	Behavioral Disorder:	_____
Exercise Induced?	_____	Dizziness/Fainting Spells:	_____
On Asthma Medications?	_____	Thyroid Problems:	_____
Ear infections:	_____	Kidney Disease:	_____
Headaches/Migraines:	_____	Seizure Disorder:	_____
Heart Condition:	_____	Injuries to bones/joints:	_____
Diabetes:	_____	High Blood Pressure:	_____
Blood Disorder:	_____	Sleep disorder:	_____

Comments: _____
_____
_____
_____

Allergies

Please check all that apply and provide explanation if needed:

_____ Food allergies*
Please list:_____
_____
_____

_____ Drug Allergies:
Please list:_____
_____
_____

_____ Bee Stings

_____ Seasonal Allergies

_____ Other Allergies
Please list:_____
_____
_____

Does the child carry an Epi Pen? Yes / No

*** Camp NEW You @ MU CANNOT guarantee that food served and prepared in the Marshall University facilities are peanut and tree nut free**

Medications camper is currently taking:

Drug Dosage Times/day How long?

_____
_____
_____
_____

Immunization History: (Please include dates & attach copy of immunization record)

DTP Series: Yes / No Date: ____/____/____
MMR: Yes / No Date: ____/____/____
Tetanus: Yes / No Date: ____/____/____
TB Test: Yes / No Date: ____/____/____
H1N1: Yes / No Date: ____/____/____

Chicken Pox (varicella): Yes / No Date: ____/____/____
TB Test: Yes / No Date: ____/____/____
Meningitis (Menactra): Yes / No Date: ____/____/____
Hepatitis Yes / No Date: ____/____/____

Has the camper ever had any serious injuries/medical conditions? Yes / No
If yes, please list and provide a brief explanation of each:

_____
_____
_____

Restrictions / Limitations while at this camp: (please be specific)

_____
_____

Physical Activity Participation (***Camper must be able to participate in most modes of physical activity to be eligible for this camp*) This child can: (Please mark all that apply) ____ walk up a flight of stairs without being winded ____ walk/run a mile ____ participate in school physical education ____ participate in muscular strengthening activities ____ maintain personal hygiene

Physician Name : _____ **Specialty:**_____ **Date** _____/_____/_____

Signature of Physician: _____ **Phone** (____)_____-_____

In my opinion I would rate this families' commitment to this program as:
_____ Not Committed _____Somewhat Committed _____Committed _____Extremely Committed

Parent/Guardian Authorization:

I (parent/guardian) _____ , agree that this health history information is correct and the person herein described has my permission to engage in all camp activities, with the exception of any restrictions/limitations as described. In the event that I can not be reached in an emergency, I hereby give permission to the medical personnel to secure proper treatment for, hospitalize, and to order injection, anesthesia or surgery for my child as named above.

Name of Parent/guardian (please print): _____
Signature: _____ Date: _____/_____/_____

Please send completed form to:
Camp NEW You @ MU
School of Kinesiology
Marshall University
Huntington, WV, 25755