SOUTHAMPTON ICE RINK
668 COUNTY ROAD 39
SOUTHAMPTON, N.Y. 11968
(P): (631) 283 – 2158
WWW.SOUTHAMPTONICERINK.COM

Participant Name: ________________________________

MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

Directions: Parents of minors must complete this form for each child participating in any sporting activities at SOUTHAMPTON ICE RINK. This form will be copied and provided to any Health Care Professional (EMS, Doctor, etc.) should your child require emergency medical treatment. Please answer all questions. Please type or print in **BLACK** ink. Attach any permission forms from your physician to dispense medication to this form. Incomplete or late forms will be returned, and minors will not be allowed to start before a complete medical form is on file.

PARTICIPANT INFORMATION

Participants Name ______________________________________ Gender ______________________________

Home Address ____ Date of Birth ________________ Age ______

City / State / Zip _______________________________________ Home Phone __________________________

EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)

Before a participant under 18 years of age can be treated, the law requires us to obtain parent / guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.

PRIMARY CONTACT

Name ________________________________

Address ______________________________

Relationship ___________________________

Home Phone ___________________________

Work Phone ___________________________

Cell Phone ____________________________

SECONDARY CONTACT

Name ________________________________

Address ______________________________

Relationship ___________________________

Home Phone ___________________________

Work Phone ___________________________

Cell Phone ____________________________

PHYSICIAN INFORMATION

Family Physician ________________________

Address ______________________________

____

Phone ________________________________

SPECIALIST INFORMATION

Specialist Name _________________________

Address ______________________________

____

Phone ________________________________

DATE OF LAST PHYSICAL EXAMINATION: ________ / ________ / __________

LIST ANY RESTRICTIONS: ____

Participant Name: ________________________________

MEDICAL HISTORY – Please indicate if the participant has any chronic childhood conditions or diseases related to the following list in the space provided below including any activity restrictions.

Arthritis & Rheumatologic Conditions
Asthma
Bones & Muscles
Brain & Nervous System
Cancer & Tumors
Digestive System
Ear, Nose & Throat
Endocrine Glands & Growth
Genetic, Chromosomal & Metabolic Conditions
Heart & Blood Vessels
Kidney & Urinary System
Learning Disorders
Lungs & Respiratory Systems
Reproductive Systems
Skin Disorders
Diabetes

DETAILS:

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____

ALLERGIES - ☐ this person has **NO** Allergies **OR** ☐ this person has allergies as follows:

Type of Allergy (food, insect, medication)	**DESCRIBE REACTION**

MEDICATIONS - ☐ this Person takes **NO** medication **OR** ☐ this person takes medications as follows:

MEDICATIONS	**DOSEAGE**	**FREQUENCY**	**DIAGNOSIS**

Note: Our staff is unable to administer any medication, (prescription or non-prescription) to the participant without a signed order by a licensed physician. The permission to dispense medication by staff for is available upon request for this purpose. Parents or guardians may not send any prescription or over the counter medication with a participant that a physician has not signed for.

Participant Name: ___________________________________

CURRENT MEDICAL CONDITIONS – Please indicate below if participant currently has any medical conditions or limitations that do not constitute a handicap or a disability that would impair or limit the participant from fully engaging in the activities provided for which the participant is registering and provide a complete description of such conditions or limitations.

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MEDICAL INSURANCE INFORMATION – Is the participant covered by more than one health plan ____ Yes ____ No

Name of Policyholder ______________________________
Policyholder ID # _________________________________
Policyholder Date of Birth __________________________
Relationship to participant __________________________
Policyholder Phone _______________________________
Medical Insurer Name _____________________________
Plan Type _______________________________________
Insurer Address __________________________________
____
Insurer Phone ____________________________________
Group Name _____________________________________
Group ID ____

PLEASE PROVIDE A COPY OF THE FRONT AND THE BACK OF ALL INSURANCE CARDS AND PRESCRIPTION ID CARDS

Prescription Carrier Name __________________________
Policyholder Name ________________________________
Carrier Address __________________________________
____
Group Name _____________________________________
Group ID ____

IMMUNIZATIONS –

The Participant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and American Academy of Pediatrics. ☐ Yes ☐ No

Please Note: For participants of the Winter Sessions a complete immunization record is REQUIRED.

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:

☐ NO ☐ YES (If yes, state type of exposure: ___________________________________)

CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me are unsuccessful, **PERMISSION** is hereby granted for the examination, treatment and medical care of the participant by Emergency Medical Services or another duly licensed healthcare facility. **PERMISSION** is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

______________________________	______________________________	______________
Signature of Parent / Guardian	**Print Name**	**Date**