

**2026 ST. BONAVENTURE E-SPORTS CAMP**

**JULY 6-10, 2026**

**HEALTH, AUTHORIZATION & RELEASE FORM**

*Confidential – Required for Participation in Camp*

**CHILD INFORMATION**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## **HEALTH HISTORY**

Check all that apply:

- Asthma
- Allergies (food/environmental/medication)
- Diabetes
- Seizures
- Heart condition
- Behavioral/emotional concerns
- Recent injury or surgery
- Other: \_\_\_\_\_

- Provide details:

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## **ALLERGIES**

- No known allergies
- Allergies – Please describe below

**Allergy**

**Reaction**

**Treatment**

## **MEDICATIONS**

- No medications
- Medications required (list below.) All medications must be in original labeled container(s)

<b>Medication</b>	<b>Dosage</b>	<b>Time</b>	<b>Reason</b>
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Campers taking any prescription medications or additional over the counter/PRN medications while at camp **MUST** be able to self-administer the medication under the supervision of the Camp Director/Designee.

**IMMUNIZATION AND PHYSICAL EXAM INFORMATION TO BE FILLED OUT BY  
PHYSICIAN**

**IMMUNIZATION RECORD**

Attach immunization record from licensed healthcare provider. Must meet NYS requirements in order to attend camp.

I certify that the attached list of immunizations submitted reflect the required/recommended immunizations for the following diseases:

All grades (2nd through 12th):

- Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)
- Hepatitis B vaccine
- Measles, Mumps, & Rubella vaccine (MMR)
- Polio vaccine (IPV/OPV)
- Varicella (Chicken Pox) vaccine

In addition to the vaccines listed above, the following are required for grades 6-12:

- Grades 6-12: Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)
- Grades 7-12: Meningococcal conjugate vaccine (MenACWY)

**Physician's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**License #:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PHYSICAL EXAM (REQUIRED)

To be completed by licensed healthcare provider. Must have been done within 12 months of start of camp.

Date of Physical: \_\_\_\_\_

Cleared for participation

Cleared with restrictions

Restrictions: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

## INSURANCE INFORMATION

Parent/guardian assumes responsibility for all medical costs

Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_

## PARENT/GUARDIAN AUTHORIZATION

I certify all information is accurate

I authorize emergency medical treatment if needed

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_