

2012 ALL STAR FIELD HOCKEY CAMP MEDICAL FORM

PLEASE COMPLETE THE **ENTIRE FORM**, INCLUDING PHYSICIAN'S SIGNATURE.
OR IF YOU ARE ATTACHING IMMUNIZATION/PHYSICAL PAPERWORK FROM YOUR DOCTOR, YOU ONLY NEED TO **COMPLETE PAGE 1**.

July 29 – August 1, 2012

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: ____/____/____ SEX: _____ SOCIAL SECURITY # ____-____-____

HOME ADDRESS: _____

HOME CITY: _____ STATE _____ ZIP CODE _____

PARENT/GUARDIAN 1: _____ RELATION: _____

DAY PHONE: (____) _____ CELL PHONE: (____) _____

PARENT/GUARDIAN 2: _____ RELATION: _____

DAY PHONE: (____) _____ CELL PHONE: (____) _____

HEALTH HISTORY - Please fill in dates where appropriate.

Illness
Frequent Ear Infections _____
Heart Defect/Disease _____
Convulsions _____
Diabetes _____
Bleeding/Clotting Disorders _____
**Asthma _____

***Allergies
Hay Fever _____
Ivy Poisoning _____
*Insect Stings _____
Medicine _____
Foods _____
*What Insects _____

Disease
Chicken Pox _____
Measles _____
German Measles _____
Mumps _____

*****Please describe care necessary to handle asthma (i.e.-use of inhaler) If Epi-Pen is required to handle allergic reaction, family must supply one*****

Medical Insurance Carrier: _____ Policy# _____

Address: _____ Phone _____

Operations or serious injuries (with dates): _____

Chronic or recurring illness: _____ Any specific activities to be restricted? _____

Name of Campers Dentist: _____ Phone _____

Name of Campers Doctor: _____ Phone _____

PARENT/GUARDIAN AUTHORIZATION: MUST BE SIGNED FOR CHILD TO PARTICIPATE IN CAMP

This Health History is correct so far as I know, and the child described herein has permission to engage in all prescribed program activities except as noted by the examining physician and me. I hereby, authorize the staff of the All Star Field Hockey Camp to provide care that includes routine diagnostic procedures (i.e.-x-rays, blood and urine test) and medical treatment to my minor camper. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during camp.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

IMMUNIZATION HISTORY AND DATES

DPT 1. _____ 2. _____ 3. _____ 4. _____	Polio 1. _____ 2. _____ 3. _____	MMR (combined) 1. _____ 2. _____ 3. _____
History of Chicken Pox Yes _____ Date _____ No _____	HIB 1. _____ 2. _____ 3. _____ 4. _____	Hepatitis B Series <small>(only for children born on or after 1/1/92)</small> 1. _____ 2. _____ 3. _____

Medical Examination

- To be filled in by a **licensed physician**.
- This examination should be performed within one calendar year of arrival at the All Star Field Camp.
- Examination for some other purpose within this period is acceptable

Code: V-Satisfactory X-Not Satisfactory (explain) O-Not Examined

Ht. _____ Wt. _____ Blood Pressure _____ Urinalysis _____

Eyes _____ Lungs _____ Allergy _____

Please describe degree of allergic reaction:

Glasses _____ Contacts _____ Abdomen _____

Hernia _____ Ears _____ Extremities _____

Nose _____ Posture (spine) _____ Throat _____

Skin _____ Heart _____ Genitalia _____

General Appraisal _____ Special Diet _____

Current Medications _____

I have examined the person described herein and have reviewed the health history. It is my opinion that this person is physically able to engage in program activities, except as noted above.

Examining Physician Signature: _____

Date of last physical examination: _____

(Exam needs to be within 1 year of the start of camp)

Please Print Physician's Name _____

Address: _____

Phone _____ **Fax** _____