MEDICAL HISTORY FORM

Amaral Soccer Camps (for campers/staff under age 18)

Note this is a two page form !!!!

Camper Information - Please Print

LAST NAME:_____ **FIRST NAME:**_____

DATE OF BIRTH:_____/_____/_____ **SEX:**_____ **STREET ADDRESS:**_____

HOME CITY:)_____ **STATE**_____ **ZIP CODE**_____

PARENT/GUARDIAN 1:_____ **RELATION:**_____

DAY PHONE: (_____**)**_____ **EVENING PHONE: (**_____**)**_____

PARENT/GUARDIAN 1:_____ **RELATION:**_____

DAY PHONE: (_____**)**_____ **EVENING PHONE: (**_____**)**_____

HEALTH HISTORY

***Please fill in dates where appropriate*.

Illness	***Allergies**	**Disease**
Frequent Ear Infections_____	Hay Fever_____	Chicken Pox_____
Heart Defect/Disease_____	Ivy Poisoning_____	Measles_____
Convulsions_____	*Insect Stings_____	German Measles_____
Diabetes_____	Medicine_____	Mumps_____
Bleeding/Clotting Disorders_____	Foods_____	
**Asthma_____	*What Insects_____	

**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

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Concussions? If yes number and time lost:_____
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_____

Name of Medical InsuranceCarrier:_____ **Policy#**_____

Address:_____ **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 Amaral Soccer 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:_____

MEDICAL EXAM FORM

To be filled in by a licensed physician.
This examination should be performed within one calendar year of arrival to 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_____ Allergies_____

Please describe degree of allergic reaction:_____

Glasses_____ Contacts_____ Abdomen_____ Ears_____

Hernia_____ Nose_____ Head (Concussion)_____

Genitalia_____ Extremities_____ Skin_____

Throat_____ Posture (spine)_____ General Appraisal_____

Heart_____Cardiovascular Disease_____

Current Medications_____ Special Diet_____

Musculoskeletal Injuries (explain)_____

Any Specific activities to be restricted?_____

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:_____

Print Physician's
Name_____Address:_____Phone_____

IMMUNIZATION HISTORY AND DATES

DPT **1.**_____
2._____
3._____
4._____
5._____

Polio **1.**_____
2._____
3._____
4._____

MMR (combined)
1._____
2._____

Meningococcal
(not required)
1._____

History of Chicken Pox

Yes _____

Date: _____

No: _____

HIB **1.**_____
2._____
3._____
4. _____

Hepatitis B Series
(only for children born on or after 1/1/92)
1. _____

2. _____

3. _____