

# Revolution Field Hockey Summer Camp Health Record

Every camper must have this health record filled out and bring it with them to camp check-in. Camps held in the following states require this form to be completed and signed by a physician before your child can participate at summer camp, (CT, MA, NY, RI).

*PLEASE DO NOT MAIL AHEAD.*

Camp Attending: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

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

Phone (Home): \_\_\_\_\_

Phone (Work): \_\_\_\_\_

Phone (Cell): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

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

Phone (Home): \_\_\_\_\_

Phone (Cell): \_\_\_\_\_

## Health History

Asthma: YES/ NO      Loss of Limb: YES/ NO  
Diabetes: YES/ NO      Orthopedic Problem: YES/ NO  
Heart Problem: YES/ NO      Depression: YES/ NO  
Mono: YES/ NO      Head Injury: YES/ NO  
Cancer: YES/ NO      Migraine: YES/ NO  
Ear Infection: YES/ NO      Tuberculosis: YES/ NO

Please explain all "yes" answers \_\_\_\_\_

\_\_\_\_\_

Other serious illness or injury: \_\_\_\_\_

List all current medications (Prescription, "over the counter" and herbal) \_\_\_\_\_

\_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_

Policy/ID Number \_\_\_\_\_

Policy Holder's Name & DOB \_\_\_\_\_

Insurance Provider Contact: Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_

*Please include a photocopy of your Health Insurance card for our records.*

Physician's Name \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

## Allergies

Aspirin yes \_\_\_\_\_ no \_\_\_\_\_

Penicillin yes \_\_\_\_\_ no \_\_\_\_\_

Sulfa yes \_\_\_\_\_ no \_\_\_\_\_

Bee Sting: yes \_\_\_\_\_ no \_\_\_\_\_

If yes, does he/she carry and Epi Pen? yes \_\_\_\_\_ no \_\_\_\_\_

Food, please list: \_\_\_\_\_

Other: \_\_\_\_\_

Please indicate Yes or No for over the counter medications that may be administered to your child if indicated due to injury and/or illness, according to the manufacturer's recommendations, by the Revolution Field Hockey Summer Camp Athletic Trainer.

## Medication: Yes No

Ibuprofen \_\_\_\_\_/ \_\_\_\_\_

Tylenol \_\_\_\_\_/ \_\_\_\_\_

Sudafed \_\_\_\_\_/ \_\_\_\_\_

Mylanta \_\_\_\_\_/ \_\_\_\_\_

Hydrocortisone Cream 1% \_\_\_\_\_

## Medication: Yes / No

Robitussin DM \_\_\_\_\_/ \_\_\_\_\_

Benadryl \_\_\_\_\_/ \_\_\_\_\_

Pepto Bismol \_\_\_\_\_/ \_\_\_\_\_

Antibiotic Ointment \_\_\_\_\_/ \_\_\_\_\_

## Immunization History (Please List Dates)

*Copy of Immunization Record Preferable.*

DPT \_\_\_\_\_ Booster \_\_\_\_\_

Polio OPV (Sabin) \_\_\_\_\_ Booster \_\_\_\_\_

Measles/Mumps/Rubella (MMR) #1 \_\_\_\_\_ #2 \_\_\_\_\_

Meningitis \_\_\_\_\_ See form, Td \_\_\_\_\_

Tuberculin Test \_\_\_\_\_ Results \_\_\_\_\_

Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Varicella \_\_\_\_\_

HIB #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Restrictions/limitations for camper while at camp?

yes \_\_\_\_\_ no \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Parent's Authorization

My child has had a recent physical on \_\_\_\_\_ and may participate in all activities in the Revolution Field Hockey Camp. I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release the Revolution Field Hockey Camps, staff, camp management and sponsors from any liability for any injury or illness incurred while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*NOTE\*\*\*All medication will be checked and kept by the trainer. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The prescribers authorization form must accompany all medication and requires the physician's signature.