



Camp Code: _____
 Due back by: ____/____/____
 (Send the original – and also bring a copy to camp)
PLEASE COMPLETE ENTIRE FORM!

Immunization and Physical form from school / physician may be submitted in lieu of completing the immunization and physical examination section below.

Student Name _____

Age at camp ____ Birth Date: ____/____/____ Gender: M F

Address: _____

City _____ State: _____ Zip: _____

Phone Number (Day): (____) _____

(Eve): (____) _____

In Case of Emergency and parent / guardian **cannot** be reached:

Contact: _____ Relationship: _____

Phone: (____) _____

Parent/Guardian Authorizations: This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine healthcare and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of SoccerPlus Camps or their designee to secure and administer treatment, including hospitalization, for the person named above.

Indemnification: The undersigned parent/guardian of the registrant, for and in further consideration of SoccerPlus Camps' accepting said registrant, hereby agrees to save and indemnify and keep harmless the said SoccerPlus Camps, its agents, and sponsors against any and all liability, claims, judgments, or demands arising as a result of any course of instruction or activity given the registrant by SoccerPlus Camps.

Signature of Parent/Guardian _____

Printed Name _____ *Date* _____

Medical Insurance Company (REQUIRED)

Ins. Co. _____

Policy # _____ Group # _____

Insured Employer _____

We recommend that a photocopy (front and back) of health insurance card be attached to this form.

Health History:

<i>Check those that apply:</i>		<i>Life Threatening Conditions</i>
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Ear Aches / Infection	<input type="checkbox"/> Asthma
<input type="checkbox"/> Gyn Problems	<input type="checkbox"/> Poison Ivy, Oak, Sumac	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Absence of a paired organ	<input type="checkbox"/> Heart Conditions / Murmur
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Food Allergies (specify)
<input type="checkbox"/> Current orthodontic appliance	<input type="checkbox"/> Mononucleosis in the past 12 months	<input type="checkbox"/> Medication Allergies (specify)
<input type="checkbox"/> Skin Problems (Acne, Eczema)	<input type="checkbox"/> Recent Illness / Infections	<input type="checkbox"/> Other Allergies ~ insect stings, hay fever, animal
<input type="checkbox"/> HBP	<input type="checkbox"/> Concussion / Head Injury	<input type="checkbox"/> Other (Please detail)
<input type="checkbox"/> Bone / Joint Injuries	<input type="checkbox"/> Other Chronic Condition	
<input type="checkbox"/> Operations	<input type="checkbox"/> Other	

*** Details of above to be completed on additional sheet ***

Individualized Order Form for ALL medications MUST also be completed.
 This form is available on the backside of this page!

Immunizations

<i>Immunizations</i>	<i>Date</i>	<i>Boosters</i>
Dtap/TD/Tdap		
Polio (3)		
Hepatitis B (3)		
MMR (2)		
TD (valid 10 y)		
Haemophilus Influenza Type B		

<i>Immunizations or proof of illness</i>	<i>Date</i>
Varicela or proof of Chicken Pox	

<i>Illness (if applicable)</i>	<i>Date</i>
Measles	
German measles	
Mumps	
Hepatitis A	
Hepatitis C	

Physical Examination: - Valid for Two Years Only and to Be Completed by a Licensed Health Care Professional ONLY!

Height		Weight	
Hearing (R / L)		Vision (R / L)	
Dental / Bite		Respiratory	
Cardiac		BP	
Hernia		Extremities	
Genitals		Skin	

RESTRICTIONS, LIMITATIONS (INCLUDING DIET):

RECOMMENDATIONS:

The above named person is in satisfactory condition and may engage in all camp activities except as noted:

Date: _____ Examining physician: _____

Telephone: (____) _____

Print physician's name: _____

State licensed in: _____ License #: _____

Address: _____

Please mail original at least 30 days prior to camp and also bring one copy to camp:
SoccerPlus, 11 Executive Drive #202, Farmington, CT 06032
Tel 860-677-7500, 1-800-KEEPER1, Fax 860-677.0460
**** PLEASE SEE REVERSE SIDE ****

Authorization for the Self-Administration of Medications

CAMPER: _____

DATE OF BIRTH: ____/____/____

WEIGHT: _____ lbs

This person takes NO medications on a routine basis.

The following form must be completed and signed by the child's physician if your child:

- Needs to take any Over the Counter Medication "as needed" provided by the parent /guardian, while at camp. (Part I)
Over-The-Counter medication must be in the original container and labeled with the child's name.
- Needs to take any routine Prescription Medications, provided by the parent /guardian, while at camp. (Part II). *Prescription medications must be in pharmacy-prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription.*

ALL MEDICATIONS AT CAMP ARE TO BE SELF-ADMINISTERED, BUT KEPT BY THE MEDICAL STAFF WHILE ON SITE.

Part I - Over-the-Counter Medications

Drug Name	Route	Dosage	Indications	Physician Order	Comments
Tylenol (EXAMPLE)	Liquid or Tabs (EXAMPLE)	Per Label (EXAMPLE)	Pain or Fever (EXAMPLE)	Yes No (EXAMPLE)	

Part II - Prescription Medications

Drug Name	Controlled Substance	Route	Dosage / Time of Administration	Indications	Physician Order	Comments / Relevant Side Effects
	Y / N					
	Y / N					
	Y / N					
	Y / N					
	Y / N					
	Y / N					

If there are Relevant Side Effects listed above, please provide plan for management for each substance.

Date: _____ Examining physician: _____ Print physician's name: _____
 Telephone: (_____) _____ State licensed in: _____ License #: _____

Authorization by Parent/Guardian for the administration of the above medication:

To nurse, first aider, director, alternate director or youth camp counselor: I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by the nurse, first aider, director, alternate director or youth camp counselor. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over-the-counter medication shall be in the original container labeled by the parent with the child's name. ***I understand that this and all medication will be destroyed if it is not picked up on the last day of camp following termination of the order.***

Name of Parent or Guardian _____ Signature _____
 _____ (Print Name)
 Street Address _____ City/Town _____ State _____ Phone (_____) _____
 Relationship to child: _____ Date: ____/____/____