



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 ****

