STAFF

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:

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

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

Immunizations

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

Immunizations or proof of illness	*Date*
Varicela or proof of Chicken Pox	

Illness (if applicable)	*Date*
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 * ****

Individualized Order Form

CAMPER:__________________________________ **DATE OF BIRTH:**____________ **WEIGHT:** ___________ **lbs.**

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

- Needs to take any standard Over the Counter Medication "As Needed" provided in the Camp's Health Center. (Part I)
- Needs to take any routine Prescription Medications, provided by the parent /guardian, while at camp. (Part II)
- Needs to take any Medication "As needed", provided by the parent /guardian, while at camp. (Part II)

Part I Standard Over-the-Counter Medications

The following medications are available in the camp health center and will be administered as needed, in accordance with the camp's written health plan, if approval is indicated by the camper's healthcare provider, to the child named above.

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

Part II Prescription Medications

Please complete with the camper's current regimen for both **Prescription and "As Needed"** medications (i.e. antibiotics, asthma inhalers, allergies,

This person takes NO medications on a routine basis.

Drug Name	Route	Dosage	Indications	Physician Order	Comments