

ECSU Youth Soccer Camp

HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical Exams Are Valid For 2 Years
From Date of Last Examination

State of Connecticut
Department of Public Health
Division Community Based Regulation
1-800-383-6063; (860) 509-8045

- Camper
 Staff

Form must be received by July 1st, 2008

Name _____ Date of Birth _____ Phone _____
Guardian _____ Address _____
Emergency Contact _____ Telephone _____
Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam _____

_____ May participate in all camp activities
_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription medication? YES NO
If yes, indicate prescription: _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST _____ Zip Code _____

Signature of Physician, APRN or PA

Date Form Signed

Telephone Number

ECSU Youth Soccer Camp 2008
Health Information and Emergency Contact Form

Name of Camper _____

In case of emergency notify:

1st

Name _____ Relationship _____

Address _____

Street

City

State

Zip

Telephone 1 _____ Telephone 2 _____

2nd

Name _____ Relationship _____

Address _____

Street

City

State

Zip

Telephone 1 _____ Telephone 2 _____

CONSENT FOR MINOR

I give my permission for medical treatment for my daughter/son, _____ if accident or illness should occur while she/he is a camper at the ECSU Youth Soccer Camp. This would include referral to a local hospital, which may result in her/his hospitalization, anesthesia and surgery should it be necessary and I am unable to be reached.

Please list any medical concerns we should be aware of (health problems, allergies, asthma, medical alert tags, prescription medications etc.)

Parent/Guardian Signature

Relationship

Date

Over Please

