



MEDICAL HISTORY FORM

Campers Name _____ Attending Camp # _____

Age _____ Gender M F

Address _____ City _____ State _____ Zip _____

Phone _____ Alternate Phone _____

Person to be reached in case of an emergency _____ Cell Phone # _____

Medical Insurance Company and Policy Number _____

Does the camper have or has he/she had problems with any of the following:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Other
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	Please list on back or other sheet
<input type="checkbox"/> Upset Stomach	<input type="checkbox"/> Bee Stings	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy	

Is the camper taking medication? _____ If yes, what are the side effects? _____

Date of last tetanus shot _____

Are there any activity restrictions the camp should be aware of? _____

FOR MINORS:

I AM UNDER THE AGE OF EIGHTEEN (18) YEARS OF AGE. MY PARENT/GUARDIAN HAS READ AND COMPLETED THE SECTION BELOW.

(If applicant is under 18 years of age, a parent or guardian must execute, in addition to the foregoing waiver and release, the following, for and on behalf of the minor.)

The undersigned, _____ (parent/guardian) the parent and natural guardian or legal guardian of _____ (minor's name) hereby the forgoing Waiver and Release for and on behalf of the minor named herein. I hereby bind myself, the minor and all other assigns to the terms of the Waiver and Release I represent that I have legal capacity and authority to act for and on behalf of the minor in the execution of the Waiver and Release.

I hereby authorize any licensed physician, emergency medical technician, hospital or other medical or health care facility to treat the minor named herein for the purpose of attempting to treat or relieve any injuries received by said minor arising out of, or relating to the soccer practice. I authorize any such Medical Provider to perform all procedures deemed medically advisable. I realize and appreciate that there is a possibility of complicating and unforeseen consequences in any medical treatment, and I assume any such risk for and on behalf of myself and said minor. I accept all responsibility for any charges incurred as a result of any medical treatment.

DATE: _____

PAR./GRD. SIGNATURE: _____ RELAT. TO MINOR: _____