



MEDICAL HEALTH EXAM/RECORD FOR CAMPERS/STAFF

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

Camper Staff

Name: _____ DOB: _____ 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? NO YES

• If *yes*, indicate prescription _____

Does the individual have allergies? NO YES Explain: _____

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

This patient 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:

Measles:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Mumps:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rubella:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Chickenpox:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tetanus:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis B:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diphtheria:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Pertussis:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Polio:	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

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

WAIVER: Must be signed by a parent or guardian of children under 18. Soccer Extreme New England and its instructors will take every precaution to ensure the safety of your child during the camp. The Soccer Extreme New England, its instructors, and owners of the facilities will not assume any liability for the unforeseen injury to your child during the camp. I understand that any injuries my child _____ might sustain during the camp will be my full responsibility. If I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp to hospitalize and secure proper treatment for the above named individual.

Signature _____ Date _____
Parents(s)/Guardian(s)