



LUSC Soccer Clinic Health Form

Camp Name/Date(s): **LUSC SUMMER 21**

June Kick off the Summer - Monday June 21st through Thursday June 24th

August Preseason- Monday August 23rd through Thursday August 26th

Every camper needs a completed health form to participate in any summer clinic program. Please fill out this form as completely as possible. Thank you!

SECTION I – BASIC CONTACT INFORMATION

Camper Name _____

LAST

FIRST

Birth date ____/____/____ Age ____ Gender Male Female

Home

Address _____

STREET

CITY

STATE

ZIP

Home Phone _____

Parent/Guardian #1 Name _____

Relationship _____

Day Phone _____ Night Phone _____

Day Phone is Home Work Cell Night Phone is Home Work Cell

Parent/Guardian #2

Name _____

Relationship: _____

Day Phone _____ Night Phone _____

Day Phone is Home Work Cell Night Phone is Home Work Cell

Additional Emergency Contact _____ Relationship _____

(In case we can't reach YOU)

Day Phone _____ Night Phone _____

Family Physician _____ Phone _____

Dentist/Orthodontist Name

_____ Phone _____

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? Yes No

If yes, indicate Insurance Carrier _____

Group # _____ Policy # _____

Policy Holder’s Name _____

Relationship to participant _____

SECTION III – ALLERGIES

Camper does not have any Allergies

Camper is allergic to

- 1. Hay Fever 2. Poison Ivy/Oak 3. Insect Stings 4. Food 5. Penicillin 6. Other Drugs 7. Other

List allergy. Describe reaction and treatment

SECTION IV – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank. You must also bring a COPY FROM YOUR DOCTOR.

DPT (Diphtheria, Pertussis, Tetanus) _____

HIB (Haemophilus Influenza B) _____

Tetanus Booster _____

Tuberculin Test _____

Polio _____

Varicella (Chicken Pox) _____

MMR (Measles, Mumps, Rubella) _____

Hepatitis B _____

SECTION V – HEALTH HISTORY-You can also just attach the PHYSICAL SUMMARY FROM YOUR CHILD’S DOCTOR.

Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please check all that apply).

- | | |
|--|---|
| <input type="checkbox"/> 1. Recent injury, illness or infectious disease | <input type="checkbox"/> 15. Measles |
| <input type="checkbox"/> 2. Chronic or recurring illness | <input type="checkbox"/> 16. German Measles |
| <input type="checkbox"/> 3. Asthma | <input type="checkbox"/> 17. Mumps |
| <input type="checkbox"/> 4. Homesickness | <input type="checkbox"/> 18. Tuberculosis |
| <input type="checkbox"/> 5. Frequent Ear Infections | <input type="checkbox"/> 19. Hepatitis |
| <input type="checkbox"/> 6. Seizure Disorder or Convulsions | <input type="checkbox"/> 20. Joint problems (knees, ankles) |
| <input type="checkbox"/> 7. Dizziness during or after exercise | <input type="checkbox"/> 21. Fractures |
| <input type="checkbox"/> 8. Chest pain during or after exercise | <input type="checkbox"/> 22. Frequent Headaches |
| <input type="checkbox"/> 9. Heart Defect/Disease | <input type="checkbox"/> 23. Head Injury |
| <input type="checkbox"/> 10. Hypertension | <input type="checkbox"/> 24. Eating Disorder |
| <input type="checkbox"/> 11. Bleeding/Clotting Disorders | <input type="checkbox"/> 25. Diarrhea or constipation |
| <input type="checkbox"/> 12. Diabetes | <input type="checkbox"/> 26. Frequent Stomachaches |
| <input type="checkbox"/> 13. Mononucleosis (in last 12 months) | <input type="checkbox"/> 27. Wears glasses or contacts |
| <input type="checkbox"/> 14. Chicken Pox | <input type="checkbox"/> 28. Been Hospitalized |
| | <input type="checkbox"/> 29. Wears a Medic Alert ID |

Please list the number and provide explanation for any checked items

Date of Last Physical Exam (Required within 18 months of camp)_____

SECTION VI – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X_____

Printed Name_____

Date_____