LUSC Soccer Clinic Health Form

Camp Name/Date(s): **LUSC 2024 Clinics**

- ❑ **April Vacation Clinic -** April 16th-18th, Tues-Thurs, 9:00-1:00pm
- ❑ **June Kick off the Summer Clinic -** June 24th-27th, Mon-Thurs, 9:00-12:00pm
- ❑ **Mid-Summer Clinic** - July 15th-18th, Mon-Thurs, 9:00-12:00pm
- ❑ **August Preseason Clinic -** Aug 19th-22nd, Mon-Thurs, 9:00-12:00pm

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_____

Cell Phone_____

Parent/Guardian #2

Name_____

Relationship_____

Cell Phone_____

Additional Emergency Contact_____Relationship_____
(In case we can't reach YOU)
Cell 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:

□ Hay Fever □ Poison Ivy/Oak □ Insect Stings □ Food
□ Penicillin □ Other Drugs □ 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 had a history of or is prone to any of the following (Please check all that apply).

- ☐ Recent injury, illness, infectious disease
- ☐ Chronic or recurring illness
- ☐ Asthma
- ☐ Homesickness
- ☐ Frequent Ear Infections
- ☐ Seizure Disorder or Convulsions
- ☐ Dizziness during or after exercise
- ☐ Chest pain during or after exercise
- ☐ Heart Defect/Disease
- ☐ Hypertension
- ☐ Bleeding/Clotting Disorders
- ☐ Diabetes
- ☐ Mononucleosis (in last 12 months)
- ☐ 14. Chicken Pox
- ☐ 15. Measles
- ☐ 16. German Measles
- ☐ 17. Mumps
- ☐ 18. Tuberculosis
- ☐ 19. Hepatitis
- ☐ 20. Joint problems (knees, ankles)
- ☐ 21. Fractures
- ☐ 22. Frequent Headaches
- ☐ 23. Head Injury
- ☐ 24. Eating Disorder
- ☐ 25. Diarrhea or constipation
- ☐ 26. Frequent Stomachaches
- ☐ 27. Wears glasses or contacts
- ☐ 28. Been Hospitalized
- ☐ 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 – AUTHORIZATIONS

☐ 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. I give my consent for emergency care to be administered by all adult staff and volunteers if deemed necessary on site at the camp. This includes administration of epinephrine auto-injectors, inhalers, and medications for diabetes care, as necessary.

Signature of Parent or Guardian X_____

Printed Name_____

Date_____