LUSC Soccer Clinic Health Form

Camp Name & Date(s): **LUSC 2026 Clinics**

Clinic	Dates	Times
☐ **April Vacation**	April 21 - 23 (Tue - Thu)	9:00 - 1:00 (9:00 - 11:00 for K)
☐ **Kick Off the Summer**	June 22 - 25 (Mon - Thu)	9:00 - 12:00
☐ **Mid-Summer**	July 13 - 16 (Mon - Thu)	9:00 - 12:00
☐ **Preseason**	August 24 - 27 (Mon - Thu)	9:00 - 12:00

A completed health form is required for each camper 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: _____

Birth Date: ___/___/___ Age: _____ ☐ Male ☐ Female

Street Address: _____

City, State, ZIP: _____

Home Phone: _____

	Parent/Guardian 1	Parent/Guardian 2
Name		
Relationship		
Cell Phone		

Emergency Contact (in case we can't reach parents/guardians above):

Name: _____

Relationship: _____

Cell Phone: _____

	Family Physician	Dentist/Orthodontist
Name		
Phone		

SECTION II – INSURANCE INFORMATION

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

Insurance Carrier: _____

Group #: _____ Policy #: _____

Policy Holder's Name: _____

Relationship to camper: _____

SECTION III – ALLERGIES

Please list camper's allergies:

☐ No Allergies	☐ Hay Fever	☐ Poison Ivy/Oak	☐ Insect Stings
☐ Penicillin	☐ Other Drugs	☐ Food	☐ Other

For each 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 the camper has had certain immunizations, simply leave blank. You must also bring a COPY FROM YOUR DOCTOR.

Vaccine	Date
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 are they prone to, any of the following? Please check all that apply.

☐ 1. Recent injury, illness, infectious disease
☐ 2. Chronic or recurring illness
☐ 3. Asthma
☐ 4. Homesickness
☐ 5. Frequent Ear Infections
☐ 6. Seizure Disorder or Convulsions
☐ 7. Dizziness during or after exercise
☐ 8. Chest pain during or after exercise
☐ 9. Heart Defect/Disease
☐ 10. Hypertension
☐ 11. Bleeding/Clotting Disorders
☐ 12. Diabetes
☐ 13. 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 Stomach Aches
☐ 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: _____

Printed Name: _____

Date: _____