

International Squash Academy Health Record

Every camper must have this health record filled out and bring it with them to camp check-in. Camps held in the following states require this form to be completed and signed by a physician before your child can participate at summer camp, (CT, MA, NY).

PLEASE DO NOT MAIL AHEAD.

Camp Attending: _____

Name: _____
Last First Middle Initial

DOB: _____ Age: _____ Sex: _____

Parent/Guardian: _____

Address: _____

Phone (Home): _____

Phone (Work): _____

Phone (Cell): _____

Emergency Contact: _____

Address: _____

Phone (Home): _____

Phone (Cell): _____

Health History

Asthma: YES/ NO Loss of Limb: YES/ NO
Diabetes: YES/ NO Orthopedic Problem: YES/ NO
Heart Problem: YES/ NO Depression: YES/ NO
Mono: YES/ NO Head Injury: YES/ NO
Cancer: YES/ NO Migraine: YES/ NO
Ear Infection: YES/ NO Tuberculosis: YES/ NO

Please explain all "yes" answers _____

Other serious illness or injury: _____

List all current medications (Prescription, "over the counter" and herbal) _____

Health Insurance Provider: _____

Policy/ID Number _____

Policy Holder's Name & DOB _____

Insurance Provider Contact: Phone _____

Mailing Address _____

Please include a photocopy of your Health Insurance card for our records.

Physician's Name _____

Physician's Signature _____

Address _____

Phone _____

Allergies

Aspirin yes _____ no _____

Penicillin yes _____ no _____

Sulfa yes _____ no _____

Bee Sting: yes _____ no _____

If yes, does he/she carry and Epi Pen? yes _____ no _____

Food, please list: _____

Other: _____

Please indicate Yes or No for over the counter medications that may be administered to your child if indicated due to injury and/or illness, according to the manufacturer's recommendations, by the Revolution Field Hockey Summer Camp Athletic Trainer.

Medication: Yes No

Ibuprofen _____/ _____

Tylenol _____/ _____

Sudafed _____/ _____

Mylanta _____/ _____

Hydrocortisone Cream 1% _____

Medication: Yes / No

Robitussin DM _____/ _____

Benadryl _____/ _____

Pepto Bismol _____/ _____

Antibiotic Ointment _____/ _____

Immunization History (Please List Dates)

Copy of Immunization Record Preferable.

DPT _____ Booster _____

Polio OPV (Sabin) _____ Booster _____

Measles/Mumps/Rubella (MMR) #1 _____ #2 _____

Meningitis _____ See form, Td _____

Tuberculin Test _____ Results _____

Hepatitis B #1 _____ #2 _____ #3 _____

Varicella _____

HIB #1 _____ #2 _____ #3 _____

Restrictions/limitations for camper while at camp?

yes _____ no _____

If yes, please explain: _____

Parent's Authorization

My child has had a recent physical on _____ and may participate in all activities in the International Squash Academy I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release the International Squash Academy, staff, camp management and sponsors from any liability for any injury or illness incurred while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp.

Parent Signature _____ Date _____

NOTEAll medication will be checked and kept by the trainer. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The "prescribers authorization form" must accompany all medication and requires the physician's signature in CT, MA & NY.