FC SARUM SOCCER CAMP
HEALTH EXAMINATION FORM

Name _____ DOB_____ Age____ M/F

Guardian _____ Phone # _____

Address _____
(street, city, state, zip)

Emergency Contact _____ Phone # _____

Insurance Carrier _____ Policy # _____ Group # _____

I hereby authorize the staff of the FC Sarum Soccer Camp to act for me according to their best judgment in any emergency requiring medical attention and hereby waive and release FC Sarum Soccer Camp from any and all liability for any injuries or illness incurred while at camp. I authorize camp medical personnel to treat medical conditions and injuries as indicated by the standing orders approved by the camp physician. I have no knowledge of any physical impairment that would be affected by the above named camper's participation in the camp program. I also understand the camp retains the right to use for publicity purposes photographs of campers taken at camp.

Parent/Guardian Signature _____ Date _____

HEALTH HISTORY (to be completed by healthcare provider) Date Examined _____

Medical Information pertinent to routine care and emergencies: _____

Does individual have allergies? Y/N Explain: _____

Is the individual taking medication? Y/N Specify dosages: _____

Any medication camper needs while at camp? Y/N
If yes, physician and parent must sign an Authorization for the Administration of Medication form authorizing that the camper is able to self-administer. Please be sure to specify medication and dosage.

IMMUNIZATION HISTORY
Please record the date (month/year)

Vaccines	Date of Basic Immunization	Date of Last Booster
DTP/DTaP/DT		
OPV/IPV		
HIB		
Hepatitis B		
MMR (1st dose)		
Measles (2nd dose)		
Varicella (chicken pox)		
Other (specify)		

Are there any medical contraindications to immunization? Y/N
If yes, specify the vaccine(s) indication the contraindications specified in the vaccine manufacturer package insert that applies.
_____

Does this individual have laboratory-confirmed proof of immunity to natural infection? Y/N
If yes, please explain and attach laboratory report: _____

Is this individual current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health? Y/N
Next appointment for immunization is scheduled for: _____

Identify any known medical or emotional illness or disorder that would currently pose a risk to others or which would currently affect the individual's functional ability to participate safely: _____

In my opinion, the individual's condition does / does not (circle) preclude his or her participation in an active soccer program.

_____ Date Form Signed _____
(Signature of MD,APRN, or PA)

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