1) CAMPER INFORMATION: LAKE PLACID SOCCER CENTRE HEALTH FORM

Name ____ Birthdate ______________Sex______

Address:____________________STREET CITY:___________________STATE ________ZIP______

2) Parent/Guardian Name ________________________

HOME ( ) _______ -_________ WORK / BUSINESS ( ) _______ -_________

Emergency Contact PERSON ____

Phone No. ( ) _______-_______ Phone No. ( ) ______ - _________

Health Insurance ____

NAME OF COMPANY

POLICY NUMBER____

3) CONSENT

I ____, verify the above information to be true and give permission to the Lake Placid Soccer Health Service staff to treat my child as they deem appropriate. I also give permission for the release of medical information to the appropriate individual(s) (for example, physician, certified athletic trainer, etc.)

____

PARENT'S/GUARDIAN SIGNATURE RELATIONSHIP TO APPLICANT DATE

4) (check all camps attending)

Lake Placid Day (age 8-18) ______ JULY 12-16 AUGUST 16-20 _____

Lake Placid ½ day Mighty Mites _____JULY 12-16 AUGUST 16-20 ______
Age 5-8

5) HEALTH HISTORY			HEIGHT: WEIGHT:		
Do you have or have you ever had:	YES	NO		YES	NO
TB or contact with tuberculosis			Neurological problems		
Rheumatic fever			Epilepsy		
Eye,Ear,Nose problems or injury			Fainting spells		
Heart Problems			Head Injury with unconsciousness		
High blood pressure			Muscle or bone problems or injuries		
Irregular or rapid heart beat			Diabetes mellitus		
Chest pain			Emotional or psychiatric problems		
Asthma			Physical handicap (s)		
Gastrointestinal problems			Operations/Hospitalizations (list below)		
Kidney problems			Other medical problems (list below)		
Allergies (please list) 1.			Current medications - if yes a completed health care provider medication form must be completed		
2.					
3.			**Please elaborate on any yes answers and attach**		

6) IMMUNIZATIONS – Applicant will NOT be allowed to participate unless a copy of child's most recent immunization record is attached. This must include influenza type, hepatitis type, measles. LPSC can accept campers who have not been immunized, but records are required by the NYS Dept. of Health to be reported.

ANY over the counter medications (EX: Advil) that come to camp MUST HAVE signed health care providers statement:

If NEEDED, please complete the following FORM – this must be completed and signed by the Camper's Health Care Provider.
LPSC MEDICATION FORM for session at: ______________________________
Individualized ORDERS for Campers name: ______________________________

DOB:______________________________ Weight: ________________

OTC section	Route	Dosage	Schedule and Indications	Comments

Standard Over the Counter / PRN Medications (will be administered at the discretion of the camp's medical staff, if approval is indicated by the camper's healthcare provider. All OTC medications indicated above must accompany child to camp. LPSC does not have a stock supply.

Drug	Route	Dosage	Schedule and Indications	Comments

Camper's Health Care Providers Name: ____

Phone:________________________________

Address:____

License Number:_________________Date:____________________

Health Care Provider Signature:____
NOTE: (only required if prescribing medication of any sort to bring to camp & over the counter medications like Advil, Tylenol)

Camper's Parent or Legal Guardians Name:____

_____________________________________ ______________________________
Signature Date