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)

SLU 1 _____ SLU 2 _____ Lake Placid _____
Junior Elite (slu) _____ Elite Field (slu) _____ Adv. GK (slu) _____

Resident Overnight CAMPER (Living at Camp) _____DAY / Commuter (Living at Home)_____

Other Community / Day Camp location:

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