

HEALTH HISTORY FOR THE MID ATLANTIC FIELD HOCKEY CAMP

Campers Last Name - _____ First Name - _____

Age at arrival of camp - _____ Date Of Birth - _____ & State Born In - _____ Grade Fall '24 - _____

*Camp Session Attending: **July 14-18** or **July 21-25**

Emergency Contact Parent/Legal Guardian with legal custody to be contacted in case of need, illness, or injury:

Name: _____ Relationship to Participant: _____

ADDRESS- _____

CITY - _____ STATE - _____ ZIP - _____

Preferred Phones: (_____) _____ (_____) _____ Email _____

Emergency Contact Name _____ Emergency Contact Phone Number (_____) _____

Please input dates for the immunizations listed below. If you are unsure of the exact date, but know the camper has received the immunization, please input "Y" in the "DATE" field. If the camper has not received the immunization, or you are unsure, please leave the field empty.

IMMUNIZATIONS		ALLERGIES		DRUG REACTION		ILLNESS/CONDITIONS	
TYPE	DATE	TYPE	YES/NO	TYPE	YES/NO	TYPE	YES/NO
Tetanus Toxoid		Hay Fever		Sulpha		German Measles	
Polio Vaccine		Asthma		Penicillin		Measles	
Measles		Eczema		Antibiotics (Type)		Mumps	
Rubella		Insect Stings		Aspirin		Chicken Pox	
Mumps		Nuts		Other		Pneumonia	
Other		Gluten		Other		Diabetes	
Other		Lactose		Other		Heart Disease	
Other		Other		Other		Covid 19	
Other		Other		Other		Other	

***Current** Prescription inhaler and/or EpiPen should be always with you!

Is the participant able to swim? Yes No

Is this participant capable of carrying a full program of fitness activities, including residential sports camp? Yes No

If "No", please state limitations below.

Date of current Sports Physical (mm/dd/yy): (*each camper must have a completed physical within the calendar year of your camp session)

Is the participant **currently** under treatment or medication for any medical and/or emotional condition? Yes No

If "Yes", explain below and list any medications.

Have you had any **recent** injuries to bones, muscles, or joints? Yes No approximate date _____

If "Yes", explain below.

Do you wear a brace for any injury? Yes No . If "Yes", explain below.

In the last year, have you had a concussion? Yes No If "Yes", approximate date _____

*Physician Release Back to play date _____

Is there anything else about this participant that we should know? Yes No

If "Yes", explain below.

ATTESTATION TO HEALTH INFORMATION I certify that the above information is complete and accurate. I have reviewed and understand the program description and activities of the program and believe that Participant is physically and emotionally fit to participate in the Program without restrictions or adaptations.

PHYSICIAN SIGNATURE - _____ DATE - _____

PRINT NAME OF PARENT OR GUARDIAN - _____

*SIGNATURE OF PARENT OR GUARDIAN - _____ DATE - _____

(*parent signature must be signed for the camper to attend camp.)

NOTE TO PARENTS: The Mid-Atlantic Field Hockey Camp prides itself in having quality medical staff at camp. We also have great cooperation with Beebe hospital and Atracare health in Lewes, which are minutes away from camp. Please upload any additional medical information that would be helpful in making the camp week a safer and healthful situation for your child. If any matter arises before camp begins, that our staff should be aware of, please notify us promptly. Please don't allow your child to attend camp if sick or injured, to jeopardize their future or the health of other campers. Thank you for your cooperation.