

Participant's Name: \_

Mother's Name: \_\_\_

Mobile/Other:

Mobile/Other:\_\_\_

Phone:

Phone:

Name: \_\_\_ Phone: \_\_

Phone:

Mobile/Other:\_\_\_

☐ Skin Cancer

□ Other: \_\_

☐ Hay Fever

□ Other: \_\_\_\_

Special Diet: \_

Insurance/Policy #: \_\_\_

☐ Convulsions/Seizures

## **MEDICAL EMERGENCY & HEALTH HISTORY INFO**

Use This Form for Same Family Members Only nd Please Print Clearly

## PLAYER 1

Birthdate: \_\_\_\_\_ Sex: \_\_\_ Weight: \_\_\_\_ Height: \_

Father's Name:

*If above is not available in an emergency, please contact:* 

Participant's Physician:

Medical Insurance Co.:\_\_\_\_

**HEALTH HISTORY INFORMATION** 

If YES to any of these or other, please specify: \_\_\_\_\_

☐ Asthma

*If YES to any of these or other, please specify:* \_\_\_

Date of last tetanus booster:

Medications to be administered at camp: \_\_\_\_

☐ Is your child under the care of a physician? *Please detail*: \_\_\_\_

☐ Does participant have any special needs or conditions that staff should be aware of? (Staple attachment if needed): \_\_\_\_\_

□ Diabetes

□ Epilepsy

□ Nosebleeds

☐ Bee/wasp Stings

Participant's Name: Birthdate:			Height:
Mother's Name:			
Phone:			
Mobile/Other:			
Father's Name:			
Phone:			
Mobile/Other:			
If above is not avail	able in a	n emergency,	please contact:
Name:			
Phone:			
Participant's Physic	ian:		
Phone:			
Medical Insurance (	Co.:		
Insurance/Policy #:			
HEALT	H HIST	ORY INFOR	MATION
☐ Convulsions/Seiz	ures	☐ Diabetes	□ Nosebleeds
☐ Skin Cancer		□ Epilepsy	
□ Other:			
If YES to any of thes	se or othe	er, please spec	ify:
☐ Hay Fever	□ As	thma	☐ Bee/wasp Sting
□ Other:			
If YES to any of thes	se or othe	er, please spec	ify:
Date of last tetanus	booster:		
Special Diet:			
Medications to be ac	ımınıster	red at camp: _	
		e ot a physicia	n? Please detail:
☐ Is your child unde	er tne car		
□ Is your child unde	er tne car		
□ Does participant l	have any	special needs	or conditions that

PLAYER 2