

GEORGETOWN WOMENS SOCCER SUMMER CAMP HEALTH FORM

In order to participate in a Georgetown University Summer Camp, each participant must submit completed versions of this Health Form, which certifies that they are physically able to participate in camp activities, and the Assumption of Risk/Parental Permission Form. Participants who have not completed these two forms will not be permitted to participate in camp activities until they are received.

Name _____ Birthdate _____ Sex _____ Age _____
Last First Middle Initial Month/Day/Year

Contact Information

Parents/Guardians _____ Home Phone(_____) _____ WorkPhone(_____) _____
Area Code & Number Area Code & Number

Home Address _____
Number & Street City State Zip Code

If parents/guardians not available in emergency, notify:

1. _____ Phone _____
Name (local contact)

Number and Street City State Zip Code

2. _____ Phone _____
Name

Number and Street City State Zip Code

Health History (check, give approximate dates, and any details you believe would be helpful)

Allergies:

Ear Infections _____ Hay Fever _____ Chicken Pox _____
Rheumatic Fever _____ Poison Ivy _____ Measles _____
Convulsions _____ Insect Sting _____ German Measles _____
Diabetes _____ Penicillin _____ Mumps _____
Behavior _____ Other? _____ Asthma _____

Operations or Serious Injuries (dates/description) _____

Chronic or Recurring Illness _____

Other Diseases or Details re: Above _____

Any specific activities to be restricted while participating in Summer Camp? _____

Important: Please notify the campus if this camper is exposed to any communicable diseases during the three weeks prior to camp attendance.

This health form is correct as far as I know, and my child/ward has permission to engage in all camp activities, except as noted herein by me and/or the examining physician. In the event that I cannot be reached in an emergency, I hereby give the administrators of the Georgetown University Summer Camp and any hospital or medical personnel they designate to provide any medical treatment which a medical provider deems necessary for the well being of my child/ward, including hospitalization, injections, anesthesia and/or surgery.

I further consent to non-emergency first aid for my child/ward while he/she is enrolled as a participant in the Summer Camp, as deemed necessary by the staff of the Summer Camp.

Signature of _____ Date: _____
Parent/Guardian:

Medical Insurance Information:

Policy Holder Name _____ Relation to Camper _____
Insurance Company _____ Policy/Group # _____

MEDICAL EXAMINATION - To be filled out by licensed physician.

This examination should be performed within 12 months of arrival at camp. Examination for other purposes within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Immunization History

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series _____ Booster _____ Tetanus Booster _____
Polio DPV (Sabin) _____ Booster _____ Typhoid _____
Measles vaccine (Live) _____ Tyberculin Test _____
German Measles (Rubella) _____ Mumps Vaccine (Live) _____
Smallpox _____ Other _____

Hgt. _____ Wt. _____ B.P. _____

Eyes _____	Extremities _____
Glasses _____	Posture (spine) _____
Ears _____	Skin _____
Nose _____	Allergy _____
Throat _____	Lungs _____
Teeth _____	Abdomen _____
Heart _____	Hernia _____

General Appraisal: _____

For Girls & Women

Has this person menstruated? _____ If so, is her menstrual history normal? _____
If not, has she been told about it? _____ Special considerations: _____

List any significant injuries, illnesses or emotional conditions about which the Georgetown University Summer Camp should be aware:

Recommendations and restrictions while in camp:

Special diet _____
Special medicine (name it) _____ Is parent sending it? _____
Strenuous activity _____
Other _____

Allergies to Medicine _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in physically strenuous athletic camp activities.

Name of Examining Physician M.D. Signature of Examining Physician

Date _____ Phone: _____

Address _____