

HEALTH FORM FOR PROGRAMS, CAMPS & CLINICS HELD AT GEORGETOWN UNIVERSITY

In order to participate in Georgetown Girls Soccer Camps & Clinics 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 _____

Contact Information
Parents/Guardians _____ Home Phone(_____) _____ Work Phone(_____) _____

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 Parent/Guardian: _____ Date: _____

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. _____
Hgb. Test _____ Urinalysis _____
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? _____

Swimming/Diving _____

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.

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

Date _____ Phone: _____

Address _____