ABBEY VILLA SOCCER CLUB CAMP HEALTH HISTORY FORM

Write in site(s) & dates attending: _____

Date of last physical examination (must be within last 18 months): _____

Please attach last physical report including immunizations. Must include name & address of the physician

Camper's Name: _____ **Date of Birth:** ___/___/_____

Address: _____

Gender: M / F **Grade Entering:**____ **Age:**____ **Contact E-mail:** _____

Emergency Contact Information During Clinic Hours - must be completed for acceptance

Parent: _____	**Parent:** _____	**Other:** _____
Home Phone: _____	**Home Phone:** _____	**Home Phone:** _____
Cell Phone: _____	**Cell Phone:** _____	**Cell Phone:** _____

GENERAL HEALTH HISTORY: (Circle **YES** or **NO**)

Medication Allergies	**YES NO**	EpiPen? **YES NO**
Food Allergies	**YES NO**	EpiPen? **YES NO**
Peanut/Nut Allergy	**YES NO**	EpiPen? **YES NO**
Environment/Seasonal Allergies	**YES NO**	EpiPen? **YES NO**
Bee Sting/Insect Bite Allergy	**YES NO**	EpiPen? **YES NO**
Hospitalization or Surgery	**YES NO**	
Asthma	**YES NO**	Inhaler? **YES NO**
Diabetes	**YES NO**	
Seizure Disorder	**YES NO**	
Heart Problems	**YES NO**	
Infectious Diseases	**YES NO**	
Bleeding/Clotting Disorders	**YES NO**	
Bowel/Bladder Problems	**YES NO**	
Skin Problems	**YES NO**	
Fears/Phobias	**YES NOß**	
Frequent Ear Infections	**YES NO**	Tubes? **YES NO**
Syndrome/Disorderss	**YES NO**	
Recent Injury or Illness	**YES NO**	
Frequent Headaches/Head Injury	**YES NO**	
Glasses/Contacts	**YES NO**	

HEALTH PROVIDER:

_____

NAME OF PEDIATRICIAN

_____

PHONE #

_____

NAME OF DENTIST

_____

DENTIST'S PHONE #

HEALTH INSURANCE:

_____

CARRIER NAME

_____

POLICY/GROUP # (required before being accepted to camp)

Detail any of the above: _____

_____

Medications being taken (name and explain): _____

_____

Operations, injuries, special restrictions (give dates): _____

CONSENT FOR MEDICAL TREATMENT [Minor]

As Parent or Legal Guardian of _____ I hereby give my conseemer- gency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb or the well-being of my dependent.

I understand that the directors & coaches of AVSC, its trust-ees, agents and officers, will not assume responsibility for accidents & medical or dental expenses incurred as a result of participation in this program. The applicant is covered by our family insurance, is in good health and able to participate in the

physical activity of a vigorous program. I hereby authorize the camp directors to act for me according to their best judgement in any emergency requiring medical attention.

Parent or Guardian Signature: _____ Date: _____