

1) CAMPER INFORMATION:

Name _____ Birthdate _____ Sex _____

Address: _____ STREET CITY: _____ STATE _____ ZIP _____

2) Parent/Guardian Name _____

HOME () _____ - _____ WORK / BUSINESS () _____ - _____

Emergency Contact PERSON _____

Phone No. () _____ - _____ Phone No. () _____ - _____

Health Insurance _____

NAME OF COMPANY

POLICY NUMBER _____

3) CONSENT

I _____, verify the above information to be true and give permission to the Lake Placid Soccer Health Service staff to treat my child as they deem appropriate. I also give permission for the release of medical information to the appropriate individual(s) (for example, physician, certified athletic trainer, etc.)

 PARENT'S/GUARDIAN SIGNATURE RELATIONSHIP TO APPLICANT DATE

4) (check all camps attending)

Lake Placid 1 _____ SLU 1 _____ SLU 2 _____ Lake Placid 2 _____

Junior Elite (slu) _____ Elite Field (slu) _____ Adv. GK (slu) _____

Resident Overnight CAMPER (Living at Camp) _____ DAY / Commuter (Living at Home)

Other Community / Day Camp location: _____

5) HEALTH HISTORY

Do you have or have you ever had:			HEIGHT:	WEIGHT:		
	YES	NO			YES	NO
TB or contact with tuberculosis			Neurological problems			
Rheumatic fever			Epilepsy			
Eye, Ear, Nose problems or injury			Fainting spells			
Heart Problems			Head Injury with unconsciousness			
High blood pressure			Muscle or bone problems or injuries			
Irregular or rapid heart beat			Diabetes mellitus			
Chest pain			Emotional or psychiatric problems			
Asthma			Physical handicap (s)			
Gastrointestinal problems			Operations/Hospitalizations (list below)			
Kidney problems			Other medical problems (list below)			
Allergies (please list)			Current medications - if yes a completed health care provider medication form must be completed			
1.						
2.						
3.			Please elaborate on any yes answers and attach			

6) IMMUNIZATIONS – Applicant will NOT be allowed to participate unless a copy of child's most recent immunization record is attached. This must include influenza type, hepatitis type, measles. LPSC can accept campers who have not been immunized, but records are required by the NYS Dept. of Health to be reported.

ANY over the counter medications (EX: Advil, Tylenol) that are coming to camp MUST HAVE signed health care providers statement:

If NEEDED, please complete the following FORM – this must be completed and signed by the Camper’s Health Care Provider.

LPSC MEDICATION FORM for session at: _____

Individualized ORDERS for Campers name: _____

DOB: _____ Weight: _____

OTC section	Route	Dosage	Schedule and Indications	Comments

Standard Over the Counter / PRN Medications (will be administered at the discretion of the camp’s medical staff, if approval is indicated by the camper’s healthcare provider. All OTC medications indicated above must accompany child to camp. LPSC does not have a stock supply.

Drug	Route	Dosage	Schedule and Indications	Comments

Camper’s Health Care Providers Name: _____ Phone: _____

Address: _____

License Number: _____ Date: _____

Signature: _____

Camper’s Parent or Legal Guardians Name: _____

Signature Date