

This record must be filled out by both campers and camp staff members  
It must be signed by both a parent and the child's Physician where noted

# Health Examination Record for World Class Lacrosse Camps

**Return To:**

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Name \_\_\_\_\_ Gender \_\_\_\_ Age \_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Health History (check)**

Chicken Pox \_\_\_\_ Measles \_\_\_\_  
German Measles \_\_\_\_ Mumps \_\_\_\_  
Whooping Cough \_\_\_\_ Other \_\_\_\_  
Details of above \_\_\_\_\_

**Allergies**

Hay Fever \_\_\_\_  
Asthma \_\_\_\_  
Ivy, Oak etc. \_\_\_\_

**Chronic/recurring illness**

Insect Stings \_\_\_\_ Earaches \_\_\_\_ Throat \_\_\_\_  
Drugs(specify) \_\_\_\_ Sinus \_\_\_\_ Infections \_\_\_\_  
Foods(specify) \_\_\_\_ Heart \_\_\_\_ Stomach \_\_\_\_  
Epilepsy \_\_\_\_ Rheumatic \_\_\_\_  
Diabetes \_\_\_\_ Menstrual \_\_\_\_

**Medications** being taken (Name and explain) \_\_\_\_\_

Operations, injuries, special restrictions (explain, give dates) \_\_\_\_\_

**Immunizations**

	Date	Booster
Diphtheria	_____	_____
Tetanus	_____	_____
Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Pertussis	_____	_____
Other	_____	_____

**Parent or Guardian Authorization (req for all persons under age 18)**

This health record is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, I hereby grant permission to the physician selected by the camp director or trainer to hospitalize secure proper treatment, injections, or anesthesia for the above named person.

\*\*\* Signature \_\_\_\_\_ Date \_\_\_\_\_  
Above printed signature \_\_\_\_\_

**Physical Examination (within past 3 years) :To be completed by a licensed Physician**

	Code (1) satisfactory	(2) Not Satisfactory	(3) Not Examined			
Height	_____	_____	_____	BP	_____	_____
Weight	_____	_____	_____	Skin	_____	_____
Contacts	_____	_____	_____	Nose	_____	_____
Required	_____	_____	_____	Eyes	_____	_____
Throat	_____	_____	_____	Glasses	_____	_____
Teeth	_____	_____	_____	Condition	_____	_____
Genitalia	_____	_____	_____	Ears	_____	_____
Hernia	_____	_____	_____	Hearing (R)	_____	_____
	_____	_____	_____	Hearing (L)	_____	_____
	_____	_____	_____	Heart	_____	_____
	_____	_____	_____	Lungs	_____	_____
	_____	_____	_____	Skeletal	_____	_____
	_____	_____	_____	Abdomen	_____	_____
	_____	_____	_____	Extremities	_____	_____

**Tests:** Urinalysis Glucose \_\_\_\_\_ Albumin \_\_\_\_\_ Tuberculin Testing (type) \_\_\_\_\_

**Restrictions, Limitations (including diet)** \_\_\_\_\_

**Medications:** \_\_\_\_\_

The above named person is in satisfactory condition and may engage in all camp activities except as noted:

Date \_\_\_\_\_ Examining Physician (signature) \_\_\_\_\_

Telephone \_\_\_\_\_ (print) Physician's Name \_\_\_\_\_

State Licensed in \_\_\_\_\_ License # \_\_\_\_\_ Address \_\_\_\_\_