



Health Form for USAO Boys/Girls Residential Soccer Camp

Date of Session _____
Company Name _____ Age _____ DOB _____ Sex _____
Name of Parent/Guardian _____
Home Address _____ City _____ State _____ Zip _____
Telephone (home) _____ (work) _____
Emergency contact if parent/guardian cannot be reached:
Name _____ Relationship _____ Phone _____
Address _____ City _____ State _____ Zip _____

Office Use
Counselor:

Room #:

In order to insure the highest degree of enjoyment and to provide the fullest protection, each camper is required to present evidence that his/her physical condition is such as to justify the expectancy of a healthy and safe camping experience.

1. Heart trouble, diabetes, asthma, or other condition we should be aware of:

2. Serious ivy, oak or sumac poisoning reaction: _____
3. Insect sting reactions: _____
4. Reactions to Penicillin or other drugs: _____
5. Are all minimum immunizations requirements up to date:

6. Date of most recent Tetanus immunizations: _____
7. Any restriction to Swimming (Y/N): _____ Recreation (Y/N): _____ Other: _____
8. Any allergic reactions to foods (i.e. nuts, etc) or substances (Y/N): _____ List if any:

9. At the time of camp, is camper under any medication or dietary regimen (Y/N): _____ List if any:

Any medication brought to camp must be in its original container and labeled for the individual for whom it is intended.

NO CHILD WILL BE ACCEPTED TO CAMP WITHOUT COMPLETED AND SIGNED FORM

My child, named above on his form, has permission to take part in all camp activities, including offsite activities under camp supervision. I agree that the camp or its personnel will not be held responsible for accidents arising thereof. I understand that attempts will be made to contact me if my child requires emergency/medical/surgical treatment, but if it is impractical to do so and/or until I can arrive at the scene. I hereby give my permission for my child to be transported for medical care and also I give my permission to the physician selected by the camp staff to secure proper treatment, to hospitalize, to order injections, anesthesia, x-ray, or surgery for my child as named above. Any financial obligation incurred will be covered by me personally or by the insurance policy listed below.

Signature _____ Date _____

Parent or Guardian

Family Health Insurance Company _____ Policy # _____

Please attach a copy of Insurance Company card that covers this camper, to this form.

Family Physician's name _____ Phone #: _____

YOU MUST PROVIDE YOUR INSURANCE COMPANY NAME, POLICY NUMBER, FAMILY PHYSICIANS NAME AND PHONE NUMBER BEFORE YOUR CHILD CAN PARTICIPATE IN CAMP ACTIVITIES.