Massachusetts
Dept. of Health
REQUIRES
the following information.
THIS IS MANDATORY!

Week(s)/Group(s)

_____ _____

_____ _____

MEDICAL INFORMATION FORM

(Print Clearly) ***(Print Clearly)***

FULL NAME:_____ D.O.B.: _____

ADDRESS:_____ Male: ☐ Female: ☐

CITY: _____ STATE:_____ ZIP:_____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

IMMUNIZATIONS: *(Dates for each dose.)*	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
Hep B	_____	_____	_____		
DTP/DT/DTaP	_____	_____	_____	_____	_____
Td	_____	_____			
OPV/IPV	_____	_____	_____	_____	
MMR	_____	_____			
Varicella	_____	_____			

☐ **Chicken Pox**: Age:_____
(Please check)

Weight:_____ Height:_____ BP:_____

Yes	**No**	***(Please Check if Applicable)***
☐	☐	**Asthma**: ☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced
☐	☐	**Allergies**: ☐ Medication ☐ Food ☐ Seasonal ☐ Other_____
☐	☐	**Anaphylactic Reaction**: ☐ Insect ☐ Food ☐ Latex
☐	☐	**EPI Pen/EPI Pen Jr.**: If YES, please include a doctors order stating emergency use of pen.
☐	☐	**Diabetes**: ☐ Type I ☐ Type II
☐	☐	**Seizure Disorder**

(Please Check)

Restrictions: The following restrictions apply to this individual -

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Other (*describe*)

_____

General Health History that applies to this individual

	Yes	**No**
Any recent injury, illness or infectious disease?	☐	☐
Have a chronic or recurring illness?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Have frequent headaches?	☐	☐
Ever have a head injury?	☐	☐
Ever been knocked unconscious?	☐	☐
Wear glasses, contacts?	☐	☐
Ever had frequent ear infections?	☐	☐
Ever passed out during or after exercise?	☐	☐
Ever been dizzy during or after exercise?	☐	☐
Ever had seizures?	☐	☐
Ever had chest pains during or after exercise?	☐	☐
Ever had high blood pressure?	☐	☐

	Yes	**No**
Ever been diagnosed with a heart murmur?	☐	☐
Ever had back problems?	☐	☐
Ever had problem with joints? (i.e. knee, ankle)	☐	☐
Have an orthopedic appliance for camp?	☐	☐
Have any skin problems? (i.e. acne, rash)	☐	☐
Had mononucleosis in the past 12 months?	☐	☐
Had problems with diarrhea/constipation?	☐	☐
Have problems with sleepwalking?	☐	☐
Have a history of bed-wetting?	☐	☐
Ever had an eating disorder?	☐	☐
Ever had emotional difficulties for which Professional help was sought?	☐	☐

Please explain any "YES" answers on next page.

Explanation of "YES" answers from previous page. _____

_____

_____

I have examined this patient and in addition, the health history and immunization records have been reviewed. There are no apparent contraindications to participating in routine hockey camp activities.

Date of Last Physical:_____ Physician's Name:_____

Physician's Address:_____

Physician's Telephone #:_____

Today's Exam Date:_____ → _____
Physician's Signature

The Parent/Guardian by his/her signature denies that any significant health problems have occurred ***since the above date***.

Today's Date:_____ → _____
Parent/Guardian Signature

CONSENT TO TREAT

I grant to medical personnel of Dynamic Skating permission to provide medical care for conditions, which arise during participation in the Dynamic Skating Hockey School. Every effort will be made to contact parents for specific permission if general anesthetic is indicated. I hereby authorize the administration of whatever medical or surgical treatment may, in the judgment of the physician, be necessary and advisable for my child. Dynamic Skating is not responsible for participants who arrive sick or injured. (See Policy Letter)

→ _____
(Child's Name)

_____ ← → _____
(Parent or Guardian Signature) (Date)

Is there anything else you think might be helpful to us in caring for this player. If yes, please attach an explanatory letter.

PLEASE NOTIFY US IF ANY MEDICAL TREATMENT OR PROGRAM WILL CONTINUE DURING THIS STAY.

Required
MUST BE FILLED OUT

EMERGENCY INFORMATION: (If parents cannot be reached)

NAME:_____ RELATIONSHIP:_____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: # _____ EMAIL ADDRESS: _____

Required
MUST BE FILLED OUT

INSURANCE INFORMATION:

Policy Holder:_____ Policy Holder D.O.B.:_____

Policy Holder Social Security #_____ - _____ - _____

Company Policy is held with:_____

PO Box # and address of Insurance Company:_____

800 # of Insurance Company:_____

Additional Information:_____

Administration of Prescription + Non-Prescription Medication to a Camper or Staff Member

In accordance with the 105 CMR 430.160 of the MA Dept. of Health

(To be completed by Parent/Guardian) **Camp Code # _____ _____ _____**

NAME OF CAMPER:_____

NAME OF PARENT/GUARDIAN:_____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

EMERGENCY #: _____ NAME _____

FOOD/DRUG ALLERGIES:_____

Please list ALL medications (including over-the-counter or non prescription drug) taken routinely. Bring enough medication to last the entire time at camp. Keep original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration

Yes ☐ No ☐

Non-Prescription Medication

Allowed to take "**over the counter**" medications during camp stay (Advil, Tylenol, Tums, etc.).

Yes ☐ No ☐

Prescription Medication

Prescription Medications will be taken during camp stay. Please list each drug separately in the boxes below (This includes inhalers/epi pens).

Name of Medication:_____

Dose given at Camp:_____ (i.e. 1x/day, 2x/day) Duration of Order:_____

Specific Directions (e.g., on an empty stomach/with meals/at bed time)_____

Special Storage Requirements:_____

Name of Medication:_____

Dose given at Camp:_____ (i.e. 1x/day, 2x/day) Duration of Order:_____

Specific Directions (e.g., on an empty stomach/with meals/at bed time)_____

Special Storage Requirements:_____

Name of Medication:_____

Dose given at Camp:_____ (i.e. 1x/day, 2x/day) Duration of Order:_____

Specific Directions (e.g., on an empty stomach/with meals/at bed time)_____

Special Storage Requirements:_____

→ _____
Parent/Guardian Signature

→ _____
Physician's Signature