eCamps Inc. Summer Camp Health Record

Every camper must have this health record filled out and bring it with them to camp check-in. Camps held in the following states require this form to be completed and signed by a physician before your child can participate at summer camp, (CT, MA, NY).

PLEASE DO NOT MAIL AHEAD.

Camp Attending:_____

Name:_____
Last First Middle Initial

DOB:_____ Age:_____ Sex:_____

Parent/Guardian:_____

Address:_____

Phone (Home):_____

Phone (Work):_____

Phone (Cell):_____

*Emergency Contact:*_____

*Phone (Home):*_____

*Phone (Cell):*_____

Health History

____May Participate in all camp activities

____May participate except for_____

_____

Does this individual have allergies? ☐ YES ☐ NO

Explain:_____

_____

Is this individual on a special diet? ☐ YES ☐ NO

Explain:_____

_____

Does the individual have special needs? ☐ YES ☐ NO

Explain:_____

_____

I have examined the above camper with in the past two years.

Date Examined_____

Physician's Signature_____

Physician's Name_____

Today's Date_____

Address_____

Phone _____

Immunization History (Please List Dates)

Copy of Immunization Record Preferable.

DPT _____ Booster_____

DT_____

Polio OPV (Sabin)_____ Booster_____

Measles/Mumps/Rubella (MMR) #1_____ #2_____

Hepatitis B #1_____ #2_____ #3_____

Chickenpox_____

Tetanus_____

Turberculin_____

Pneumococcal Conjugate_____

Haemophilus Influenza b (HIB)_____

Insurance Information

*Health Insurance Provider:*_____

Policy/ID Number_____

Policy Holder's Name & DOB_____

*Insurance Provider Contact: Phone*_____

Mailing Address_____

Please include a photocopy of your Health Insurance card for our records.

Parent's Authorization

This health history is correct so far as I know, and the person herein described has permission to participate in all activities except as noted. I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release eCamps Inc, the Revolution Field Hockey Camps, staff, camp management and sponsors from any liability for any injury or illness incurred while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp.

Parent Signature_____Date_____

NOTEAll medication will be checked and kept by the trainer. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The "prescriber's authorization form" must accompany all medication and requires the physician's signature in CT, MA & NY.