eCamps Inc. Summer Camp Health Record and Medical Release

Every camper must have this health record filled out and bring it with them to camp check-in. Camps held in CT, MA or NY require this form to be completed and signed by a physician before your child can participate at summer camp. An attached physician's signed physical dated within two years from the start of camp will suffice.

PLEASE DO NOT MAIL AHEAD.

Camp Attending_____

Camper Name_____

Last First Middle Initial

DOB_____ Age_____ Gender_____

Parent/Guardian_____

Address_____

Phone (Home)_____

Phone (Work)_____

*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_____

Does the individual have special needs? YES NO

Explain_____

_____

I've examined the above camper within the past 2 years. YES NO

Date Examined_____

Physician'sSignature*_____

Physician'sName_____

Date_____

Address_____

Phone_____

****PHYSICIAN's SIGNATURE ONLY REQUIRED FOR CAMPS HELD IN CT, MA or NY***

Insurance Information

*Health Insurance Provider*_____

Policy/ID Number_____

Policy Holder's Name & DOB_____

*Insurance Provider Contact: 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)_____

Parent's Authorization

I warrant and represent to eCamps Inc - Revolution Field Hockey, that I am the parent and/or guardian of the above-named participant and that I am authorized to execute this Consent and Release on behalf of my minor child. 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, Revolution Field Hockey, staff, camp management and sponsors from any liability and for all claims resulting from any injuries or ilnessess sustained by my child while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF THE SPORT AND CAMP ACTIVITIES. I hereby give permission to the coaches, training staff, and other medical professionals to provide medical care as deemed necessary to my child in case of any inkiry or illness, and I agree that I will be financially responsible for the cost of the same. I also acknowledge receipt of concussion information that is provided via link in the confirmation packet.

Parent Signature _____Date_____

*****NOTE***All medication will be checked and kept by the trainer. All prescription medications must be in their original casebox with the legible prescription label; including inhalers. The "prescribers authorization form" must accompany all medication and requires the physician's signature in CT, MA, & NY. The Administration of Medication and the Individual Care of Camper Plan forms must accompany all medication for camps in CT. This form is available for download on FHCamps.com.**