

# GOLD STAR SOCCER - HEALTH FORM

## CAMPER IDENTIFICATION / FAMILY CONTACT INFORMATION:

|                                       |                                   |                              |                    |                     |                |     |
|---------------------------------------|-----------------------------------|------------------------------|--------------------|---------------------|----------------|-----|
| <b>Child's First &amp; Last Name:</b> | <b>Grade &amp; School in fall</b> | <b>Birth Date:</b>           | <b>Hair Color:</b> | <b>Eye Color:</b>   | <b>Height:</b> |     |
| (male / female)                       | grade at                          |                              |                    |                     |                | - - |
| (male / female)                       | grade at                          |                              |                    |                     |                | - - |
| Home Street Address:                  | City:                             | Zip Code:                    | Home Phone:        |                     |                |     |
| Mothers Name:                         | Mothers Cell Phone                | Mothers Place of Employment: |                    | Mothers Work Phone: |                |     |
| Fathers Name:                         | Fathers Cell Phone                | Fathers Place of Employment: |                    | Fathers Work Phone: |                |     |

## IF PARENT NOT AVAILABLE IN AN EMERGENCY, PLEASE CONTACT:

|                                                                                         |                      |                   |                                                                                                                             |             |
|-----------------------------------------------------------------------------------------|----------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------|
| Emergency Contact Name:                                                                 | Address:             | Cell Phone:       | Home Phone:                                                                                                                 | Work Phone: |
| Child's Physician:                                                                      | Physician's Address: | Physicians Phone: | Is the participant covered by family medical / hospital insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO |             |
| Child's Dentist/Orthodontist:                                                           | Dentist's Address:   | Dentist's Phone:  | Carrier or plan name: _____                                                                                                 |             |
| <b>Please attach photocopy of front and back of health insurance card to this form.</b> |                      |                   | Policy / Group #: _____                                                                                                     |             |
|                                                                                         |                      |                   | Hospital Preference: <input type="checkbox"/> Bay State <input type="checkbox"/> Mercy                                      |             |

## LIST OF ALL KNOWN ALLERGIES

|                                                                                                |                                                                                                       |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>Medication Allergies (list)</b>                                                             | <b>Describe reaction and management of the reaction (attach a separate piece of paper, if needed)</b> |
| _____                                                                                          | _____                                                                                                 |
| _____                                                                                          | _____                                                                                                 |
| <b>Food Allergies (list)</b>                                                                   |                                                                                                       |
| _____                                                                                          |                                                                                                       |
| _____                                                                                          |                                                                                                       |
| <b>Other Allergies (list) – include bee/insect stings, hay fever, asthma, poison oak, etc.</b> |                                                                                                       |
| _____                                                                                          |                                                                                                       |
| _____                                                                                          |                                                                                                       |

## MEDICATIONS BEING TAKEN

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

This person **takes NO medications** on a regular basis. OR  This person **takes medications** as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Identify any medications taken during the school year that participant does/may not take during the summer (Ritalin, etc.):

## MEDICAL INFORMATION

## IMMUNIZATION RECORD

| Which of the following has the participant had?<br><input type="checkbox"/> Measles <input type="checkbox"/> Hepatitis A<br><input type="checkbox"/> Chicken Pox <input type="checkbox"/> Hepatitis B<br><input type="checkbox"/> German Measles <input type="checkbox"/> Hepatitis C<br><input type="checkbox"/> Mumps <input type="checkbox"/> _____<br><br><b>Tuberculosis (TB) Mantoux Test</b><br>Date of last test _____ <b>Result:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><br><b>Child's Blood Type:</b><br><br><b>Additional Medical Notes:</b> | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">VACCINE NAME</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> </tr> </thead> <tbody> <tr><td>D T P . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>TD (tetanus / diphtheria) . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Varioella (chicken pox) . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Polio . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Haemophilus influenza B . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Hepatitis B . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Small Pox . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>M M R . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>    or Measles . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>    or Mumps . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>    or Rubella . . . . .</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table> | VACCINE NAME | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | D T P . . . . . |  |  |  |  |  |  | TD (tetanus / diphtheria) . . . |  |  |  |  |  |  | Varioella (chicken pox) . . . . |  |  |  |  |  |  | Polio . . . . . |  |  |  |  |  |  | Haemophilus influenza B . . . . |  |  |  |  |  |  | Hepatitis B . . . . . |  |  |  |  |  |  | Small Pox . . . . . |  |  |  |  |  |  | M M R . . . . . |  |  |  |  |  |  | or Measles . . . . . |  |  |  |  |  |  | or Mumps . . . . . |  |  |  |  |  |  | or Rubella . . . . . |  |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------|-------|-------|-------|-------|-------|-----------------|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|
| VACCINE NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Mo/Yr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Mo/Yr        | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| D T P . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| TD (tetanus / diphtheria) . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| Varioella (chicken pox) . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| Polio . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| Haemophilus influenza B . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| Hepatitis B . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| Small Pox . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| M M R . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| or Measles . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| or Mumps . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |
| or Rubella . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |       |       |       |       |       |       |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                 |  |  |  |  |  |  |                                 |  |  |  |  |  |  |                       |  |  |  |  |  |  |                     |  |  |  |  |  |  |                 |  |  |  |  |  |  |                      |  |  |  |  |  |  |                    |  |  |  |  |  |  |                      |  |  |  |  |  |  |

(OVER)

**GENERAL QUESTIONS**

Explain any restrictions of activity (e.g. what cannot be done, what adaptations or limitations are necessary)

| <b>Has/does the participant:</b>                                    | <b>YES</b>               | <b>NO</b>                |                                                                                       | <b>YES</b>               | <b>NO</b>                |
|---------------------------------------------------------------------|--------------------------|--------------------------|---------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 01. Had any recent injury, illness or infectious disease? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever been diagnosed with a heart murmur? . . . . .                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 02. Have a chronic or recurring illness/condition? . . . . .        | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? . . . . .                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 03. Ever been hospitalized? . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g., knees, ankles)? . . . . .                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 04. Ever had surgery? . . . . .                                     | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp? . . . . .                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 05. Have frequent headaches? . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g., itching, rash, acne)? . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 06. Ever had a head injury? . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? . . . . .                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 07. Ever been knocked unconscious? . . . . .                        | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? . . . . .                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 08. Wear glasses, contacts or protective eye wear ? . . . . .       | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months? . . . . .                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 09. Ever had frequent ear infections? . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? . . . . .                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> | 24. Ever fainted at the sight of blood?                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had an eating disorder? . . . . .                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> | 26. Does your child have any special needs or conditions? . . . . .                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had emotional difficulties for which professional help was sought? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure? . . . . .                         | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                       |                          |                          |

Please explain any "YES" answers, noting the number of the questions. \_\_\_\_\_

**AUTHORIZED CHECK-OUT / PICK UP LIST**

The following people have my complete permission to take away / pick up my child(ren) at anytime, from Gold Star. (Do not list mother & father).

| <b>First &amp; Last Name</b> | <b>Phone #:</b> | <b>Drivers License #</b> | <b>What is their relationship to you and your child:</b>                       |
|------------------------------|-----------------|--------------------------|--------------------------------------------------------------------------------|
|                              |                 | REQUIRED                 | ( <input type="checkbox"/> Emer. Contact <input type="checkbox"/> parent of: ) |
|                              |                 | REQUIRED                 | ( <input type="checkbox"/> Emer. Contact <input type="checkbox"/> parent of: ) |
|                              |                 | REQUIRED                 | ( <input type="checkbox"/> Emer. Contact <input type="checkbox"/> parent of: ) |
|                              |                 | REQUIRED                 | ( <input type="checkbox"/> Emer. Contact <input type="checkbox"/> parent of: ) |
|                              |                 | REQUIRED                 | ( <input type="checkbox"/> Emer. Contact <input type="checkbox"/> parent of: ) |
|                              |                 | REQUIRED                 | ( <input type="checkbox"/> Emer. Contact <input type="checkbox"/> parent of: ) |

YES, I give my full permission for my child(ren) to check-out of and leave Gold Star Sports on their own, without a parent or guardian.

**ADDITIONAL COMMENTS / NOTES TO THE CAMP STAFF:**

*One of our main goals at Gold Star Sports is to really get to know your child. Please feel free to list anything here that may help us get to know him/her better. You may also use this space to write any concerns you may have.*

**PARENT / GUARDIAN AUTHORIZATIONS:**

This health history is correct and complete as far as I know, and the person/people herein described has/have permission to engage in all camp activities excepted as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records for insurance purposes or medical transport. I give permission to the camp to arrange any related transportation for me/my child/children. I hereby give my full permission to any medically trained personnel and/or physician selected by the camp to secure and administer any treatment, including hospitalization, for my child/children and/or the person/people named on the previous page, Page 1 of 2. This completed form may be photocopied.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date

**For Camp Staff Use Only**

|                       |  |
|-----------------------|--|
| Medications Received: |  |
| Additional Notes:     |  |
|                       |  |
|                       |  |