

# BOSTON SOCCER ACADEMY HEALTH HISTORY FORM

ONE FORM FOR EACH WEEK OF CLINIC ATTENDED. PLEASE PHOTOCOPY IF NECESSARY. [2/18]

Write in site(s) & dates attending: \_\_\_\_\_

Date of last physical examination (must be within last 24 months): \_\_\_\_\_

**Please attach last physical report including immunizations. Must include name & address of the physician**

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_

Gender: M / F Grade Entering: \_\_\_\_\_ Age: \_\_\_\_\_ Contact E-mail: \_\_\_\_\_

**Emergency Contact Information During Clinic Hours - must be completed for acceptance**

Parent: \_\_\_\_\_ Parent: \_\_\_\_\_ Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**GENERAL HEALTH HISTORY:** (Circle YES or NO)

Medication Allergies	YES NO	EpiPen? YES NO
Food Allergies	YES NO	EpiPen? YES NO
Peanut/Nut Allergy	YES NO	EpiPen? YES NO
Environment/Seasonal Allergies	YES NO	EpiPen? YES NO
Bee Sting/Insect Bite Allergy	YES NO	EpiPen? YES NO
Hospitalization or Surgery	YES NO	
Asthma	YES NO	Inhaler? YES NO
Diabetes	YES NO	
Seizure Disorder	YES NO	
Heart Problems	YES NO	
Infectious Diseases	YES NO	
Bleeding/Clotting Disorders	YES NO	
Bowel/Bladder Problems	YES NO	
Skin Problems	YES NO	
Fears/Phobias	YES NO	
Frequent Ear Infections	YES NO	Tubes? YES NO
Syndrome/Disorders	YES NO	
Recent Injury or Illness	YES NO	
Frequent Headaches/Head Injury	YES NO	
Glasses/Contacts	YES NO	

**HEALTH PROVIDER:**

NAME OF PEDIATRICIAN

PHONE #

NAME OF DENTIST

DENTIST'S PHONE #

**HEALTH INSURANCE:**

CARRIER NAME

POLICY/GROUP # (required before being accepted to camp)

Detail any of the above: \_\_\_\_\_

Medications being taken (name and explain): \_\_\_\_\_

Operations, injuries, special restrictions (give dates): \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT [Minor]**

As Parent or Legal Guardian of \_\_\_\_\_ I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb or the well-being of my dependent.

*I understand that the directors & coaches of Boston Soccer Academy, or anyone associated with either Shore Country Day, Ipswich HS, The Town of Swampscott, Tower School, Medford HS, Wellesley College, Greater Lawrence Tech or any other site used by Boston Soccer Academy, its trustees, agents and officers, will not assume responsibility for accidents & medical or dental expenses incurred as a result of participation in this program. The applicant is covered by our family insurance, is in good health and able to participate in the physical activity of a vigorous program. I hereby authorize the camp directors to act for me according to their best judgement in any emergency requiring medical attention. I will hold harmless Shore Country Day, Ipswich HS, The Town of Swampscott, Tower School, Medford HS, Wellesley College, Greater Lawrence Tech or any other site used by Boston Soccer Academy, its trustees, agents and officers of any and all liability actions, causes of action, claims & demands of every kind and nature whatsoever which may arise in connection either with or resulting from participation in any of its activities.*

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_