



**2011 Women's Camp HEALTH/PHYSICAL FORM**

\_\_\_\_\_ July 22-24 Team Session      \_\_\_\_\_ July 27-30 Individual Session

**NAME:** \_\_\_\_\_ **DATE of BIRTH:** \_\_\_\_\_

**HEALTH INSURANCE CO:** \_\_\_\_\_ **MEMBERSHIP NO.:** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE NO.:** \_\_\_\_\_

**APPLICANT HAS HAD (please provide dates)**

	<i>DISEASE</i>	<i>VACCINATION</i>	<i>IMMUNIZATION</i>
MEASLES	_____	_____	
HEPATITIS B	_____	_____ (for children born on or after 1/1/92)	
MUMPS	_____	_____	
RUBELLA	_____	_____	
WHOOPING COUGH	_____	_____	
CHICKEN POX	_____	_____	
TETANUS			_____
DIPHTHERIA			_____
POLIO			_____

**PLEASE CHECK THE APPLICANTS FOLLOWING HEALTH PROBLEMS IN THE PAST or PRESENT AND GIVE THE YEAR. Have you ever had, or now have, any of the following?**

<b>General</b>	<b>Yes</b>	<b>No</b>	<b>Briefly Explain</b>
Asthma	___	___	_____
Tuberculosis	___	___	_____
Polio	___	___	_____
Diabetes	___	___	_____
Allergies	___	___	_____
* Medications	___	___	_____
* Food	___	___	_____
* Bee Stings	___	___	_____
Fungus	___	___	_____
Herpes	___	___	_____
Staph (Boils)	___	___	_____
Cyst or Lumps	___	___	_____
Spleen Injury	___	___	_____
Contact Lenses	___	___	_____

**Are you currently taking any medications, prescribed or otherwise?**    \_\_\_ yes    \_\_\_ no

**If yes, please explain:** \_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

<b>Neurological</b>	<b>Yes</b>	<b>No</b>	<b>Briefly Explain</b>
Head Injury	___	___	_____
* Concussion	___	___	_____
* Nose Fracture	___	___	_____
Neck Injury	___	___	_____
Heat Problems	___	___	_____

<b>Cardiopulmonary</b>	<b>Yes</b>	<b>No</b>	<b>Briefly Explain</b>
Chest Pains	___	___	_____
Palpitations	___	___	_____
Shortness of Breath	___	___	_____
High Blood Pressure	___	___	_____
Heart Murmur	___	___	_____
Fainting	___	___	_____

<b>Orthopedic</b>	<b>Yes</b>	<b>No</b>	<b>Briefly Explain</b>
Foot/Ankle	___	___	_____
Lower Leg/Knee	___	___	_____
Thigh/Hip/Groin	___	___	_____
Back/Ribs	___	___	_____
Neck/Shoulder	___	___	_____
Arm/Elbow/Wrist	___	___	_____
Hand/Fingers	___	___	_____
Other	___	___	_____

**Please list any other pertinent medical history:**  
\_\_\_\_\_  
\_\_\_\_\_

**Attending Physician:**

Current Vitals

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ B.P. \_\_\_\_\_

The above named individual has received a pre-participation physical examination for her general health and is cleared for activity in Field Hockey Camp.

Date: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
Physician Phone: \_\_\_\_\_

**Participant:**

The responses to the questions on this form are correct to the best of my knowledge.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian:**

I understand and accept that risk of injury is possible while playing or practicing the sport of field hockey. I authorize the directors and athletic trainers to act for me according to their best judgment in any emergency requiring medical attention.

Parent and/or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Note-** If you submit another physical in place of this form, IT MUST HAVE THE SAME MEDICAL INFORMATION, ALONG WITH THE PHYSICIANS SIGNATURE, ADDRESS, PHONE NUMBER, PARENT SIGNATURE, PARTICIPANT SIGNATURE, AND IS WITHIN 1 YR OF THE COMPLETION OF THE CAMP SESSION YOUR CHILD WILL BE ATTENDING.