

**THIS FORM REQUIRES TWO SIGNATURES, ONE BY A PARENT OR GUARDIAN AND ONE BY A PHYSICIAN!!!**

**HOLLY SHORES FIELD HOCKEY ACADEMY**

**Personal Health and Medical Record**

THE NAME OF MY FAMILY'S MEDICAL INSURANCE COMPANY IS: \_\_\_\_\_

THE POLICY NUMBER IS: \_\_\_\_\_

*It is advisable to send your daughter with a photo copy of your insurance card & prescription card!!*

NAME	DATE OF BIRTH
STREET ADDRESS	AGE                      SEX
CITY, STATE, ZIP CODE	

**IN CASE OF EMERGENCY, NOTIFY**

Name	Relationship
Street Address	Home Phone
City, State, Zip Code	Other Phone

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Street Address	Home Phone
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**EMERGENCY MEDICAL INFORMATION**

Has or Is Subject to (check):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Allergy or reaction to any medicine, food, plant, animal or insect toxin                  |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Any other condition that may require emergency or special care, medications or knowledge. |
| <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Contact Lenses      |  |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> AIDS                |  |

Explain, if Necessary: \_\_\_\_\_

**ACTIVITY PARTICIPATION**

Please check:

Approved for ALL activities including competitive field hockey

Except as noted: \_\_\_\_\_

**IMMUNIZATIONS**

<u>Vaccines:</u>	<u>Date Rec'd</u>	<u>Has Had</u>	<u>Vaccination</u>	<u>Disease</u>	<u>Check if Needed</u>
Tetanus	_____	Measles	_____	_____	_____
Diphtheria	_____	Mumps	_____	_____	_____
Polio	_____	Rubella	_____	_____	_____
_____	_____	Whooping Cough	_____	_____	_____
_____	_____	Chicken Pox	_____	_____	_____

**MEDICAL HISTORY**

Most Recent Physical Examination Date: \_\_\_\_\_ Do you have any current health problems?  
 \_\_\_\_\_ Yes (explain below) \_\_\_\_\_ No

Are you now under medical care or taking any medications? \_\_\_\_\_ Yes (explain below) \_\_\_\_\_ No  
 Has there been any surgery, illness, allergy or change in health status since last physical exam?  
 \_\_\_\_\_ Yes (explain below) \_\_\_\_\_ No

Disease or Past/Present History of:

Yes	No	Year	Details	Yes	No	Year	Details
___	___	_____	Serious Illness	___	___	_____	Stomach/Bowels
___	___	_____	Serious Injury	___	___	_____	Appendicitis
___	___	_____	Deformity	___	___	_____	Kidneys/Bladder
___	___	_____	Surgery	___	___	_____	infection
___	___	_____	Skin/Glands	___	___	_____	bed wetting
___	___	_____	Ears	___	___	_____	Menstrual Problems
___	___	_____	Eyes	___	___	_____	Hernia Rupture
___	___	_____	Nose/Sinus	___	___	_____	Back/Limbs/Joints
___	___	_____	Teeth	___	___	_____	Sleepwalking
___	___	_____	Throat/Tonsils	___	___	_____	Behavioral Condition
___	___	_____	Dentures	___	___	_____	Other (specify)
___	___	_____	Bridge	___	___	_____	_____
___	___	_____	Chest/Lungs	___	___	_____	_____
___	___	_____	Heart	___	___	_____	_____
___	___	_____	Murmur	___	___	_____	_____
___	___	_____	Rheumatic Fever	___	___	_____	_____

**AUTHORIZATION**

To the best of my knowledge, history is correct and complete. I know of no reason to restrict applicant's activity and give permission for participation in all activities except as specifically noted herein. In the event that I cannot be reached in an **emergency**, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, to order injection, anesthesia or surgery for my child as named above.

DATE	Signature of Parent/Guardian	Signature of individual (if over 18)

**PHYSICIAN'S STATEMENT**

The individual named above has been examined. In addition, the above health history and immunization records have been reviewed. There are no apparent contraindications to participating in either routine activities or competitive field hockey.

Signed: \_\_\_\_\_ MD D.O.

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