

DO NOT MAIL

**BRING THIS FORM WITH YOU TO CAMP
HUGH SEYFARTH'S SOCCER CAMPS**

DO NO MAIL

Please fill out this form **COMPLETELY**. It is important for the provision of proper medical care. The section marked "Physician's Comments" need only be completed if the participant has a major health problem. When older participants are seen for minor illnesses and injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the camp director and/or athletic trainer will try to contact the parents to keep them informed. The parent's signature on the medical treatment authorization allows us to go ahead with treatment in these circumstances. The local hospital or a member of the Hugh Seyfarth's Soccer Camp staff will continue to call until contact is made with the parent or guardian.

MEDICAL HISTORY

PERSONAL INFORMATION (Please Print)

Name: _____ Social Security # _____
Last First Middle

Home Address: _____
Street City State Zip

Phone: () _____ Date of Birth: ____/____/____ Sex: Male Female

In case of emergency, notify: _____
Name of parent or next of kin Relationship

Address: _____
Street City State Zip

Home Phone: () _____ Business Phone: () _____

Business Address of Parent or Next of Kin: _____

If unable to contact either of above, name & phone of another responsible person: _____

Family Physician: _____ Address: _____

Phone: () _____

FAMILY HISTORY

Do you have a **family** history of: (Please Circle)

Diabetes Tuberculosis Cancer Heart Disease Kidney Disease Migraine

PERSONAL HISTORY

DPT _____ Most Recent Tetanus Booster _____

MMR _____ Polio _____

Have you had the chicken pox? _____ Allergies- particularly to medications-please list:

Have you ever had any of the following? (Please check)

