QuickTime™ and a
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are needed to see this picture.

2009 Women's Camp HEALTH/PHYSICAL FORM

________ December 20 – 22

NAME:____DATE of BIRTH:____________________

HEALTH INSURANCE CO:_________________________MEMBERSHIP NO.:_________________

EMERGENCY CONTACT:__________________________PHONE NO.:_______________________

APPLICANT HAS HAD (please provide dates)

	DISEASE	*VACCINATION*	*IMMUNIZATION*
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?

General	**Yes**	**No**	**Briefly Explain**
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 ____

Neurological	**Yes**	**No**	**Briefly Explain**
Head Injury	___	___	___________________________________
* Concussion	___	___	___________________________________
* Nose Fracture	___	___	___________________________________
Neck Injury	___	___	______________________________________
Heat Problems	___	___	______________________________________

Cardiopulmonary	**Yes**	**No**	**Briefly Explain**
Chest Pains	___	___	______________________________________
Palpitations	___	___	______________________________________
Shortness of Breath	___	___	______________________________________
High Blood Pressure	___	___	______________________________________
Heart Murmur	___	___	______________________________________
Fainting	___	___	______________________________________

Orthopedic	**Yes**	**No**	**Briefly Explain**
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 Lacrosse 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.

____ Date__________________
Participant's Signature

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

____ Date__________________
Parent and/or Guardian's Signature

<u>*Note</u>- 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.