Northern Edge Lacrosse Club

Participant's Name___________________

Northern Edge Lacrosse Club Health Form

This form must be completed and signed by the camper's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while at practice or traveling to a tournament. This form will be returned to you if it is incomplete. Please type or print in black ink.

PLAYERS INFORMATION

Player's Name____
Permanent Address____ Date of Birth_____________ Sex _____
City/State/Zip ____ Home Phone ______________________
Cell Phone __________________________________ Email____
High School/Middle School ____________________________________HS Grad Year _____________________
Parents Cell Phone____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:
Name ____________________________________
Relation to camper____________________________
Daytime Phone _____________________________
Evening Phone ______________________________
Cell Phone__________________________________

Backup contact (relative or friend):
Name____
Relation to camper ______________________________
Daytime Phone _________________________________
Evening Phone _________________________________
Cell Phone_____________________________________

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No
If yes, provide the following information which is required by Duke University Medical Center to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name_____________________________________ P.H.'s Date of Birth______________
Address ____ Relation to camper ______________
City/State/Zip____Ocupation______________________
P.H.'s Employer____
Employer's Address____
Insurance Company____
Insurance Company's Address____
Policy #____Plan #________________________

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named player/participant, authorize the Northern Edge Lacrosse staff to seek medical treatment for the camper as they see necessary at University of Vermont's Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the camper's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the camp staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the staff will notify me or my designee as soon as possible if any and all diagnoses and treatments are made.

_________________________________ _____________________________ ________
Legal Guardian's Signature Print Name Date

(2-sided form)

Northern Edge Lacrosse Club

Participant's Name____________________

Directions: Completion of this form by a parent or guardian is required before a student can enter camp. Please answer all questions. Incomplete forms will be returned to you for the missing information. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

DOES THE PLAYER CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies:______________________________

Food allergies:______________________________

Allergies to insect bites:______________________________

Special dietary needs:______________________________

Asthma:______________________________

Frequent headaches:______________________________

Dizziness or seizures:______________________________

LIST: Other health problems:______________________________

____

Limitations of Activities:______________________________

____

Medications the camper is currently taking:______________________________

____

____

(**please note**: Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. Yes No

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MEDICAL HISTORY

IMMUNIZATION DATES:

Measles______________________

Mumps______________________

Rubella______________________

OR MMR______________________

Last Tetanus______________________

(DPT, TT, or TD)

Polio Series completes______________

Date of last medical check-up:____________

Reasons for any hospitalization in past 5 years:

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PHYSICIAN'S INFORMATION *(to be completed by physician)* Please **PRINT** the following information:

Physician's Name:______________________________

Address:______________________________

City/State/Zip:______________________________

Telephone:______________________________

I have examined the above named camper and found her to be able to participate in all activities of Northern Edge Lacrosse Travel Club Team.

______________________________ Physician's Signature

______________________________ Print Name

__________ Date

(2-sided form)