# Northern Vermont Field Hockey Club Health Form

**CAMPER'S NAME** ____________________

*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 camp is in session. This form will be returned to you if it is incomplete. Please type or print in black ink.*

## CAMPER INFORMATION

Camper's Legal Name______________________________ Date of Birth___/___/_______ Sex ________________

Camper's Preferred Name (if different than above) _______________ Camper's Pronouns _______________________

Permanent Address__________________________________ City/State/Zip __________________________________

Home Phone ______________ Parent Cell Phone____________________ Camper Cell phone___________________

Parent Email_________________________________________ Camper Email__________________________________

Camper High School __________________________________ Camper HS Grad Year____________________

## EMERGENCY CONTACT INFORMATION

*Person to contact first:*

Name _________________________ Relationship to Athlete ________________ Daytime Phone _________________

Evening Phone _____________________ Email _________________________________________________________

*Backup contact (relative or friend)*

Name _________________________ Relationship to Athlete ________________ Daytime Phone _________________

Evening Phone _____________________ Email _________________________________________________________

## INSURANCE POLICY INFORMATION

*The above-named youth is covered by health insurance: Yes / No If yes, provide the following information which is required by Hospitals to expedite treatment and to facilitate the billing process.*

Policy Holder's (P.H.) Name _________________ P.H.'s Date of Birth __/__/____ Relationship to Athlete ___________

Address __________________________________ City/State/Zip __________________________________________

Occupation _______________________________ 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 athlete, authorize the Northern Vermont Field Hockey Club/ Vermont staff to seek medical treatment for the athlete as they see necessary, at the Local Hospital 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 athlete'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 athlete. 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 Camp staff will make a good faith effort to contact me of the above-named person(s) before seeking treatment. If this is not possible, I understand that the Camp staff will notify me or my designee as soon as possible if any and all diagnoses and treatment are made.

____________________________________ ______________________ _____________

Legal Guardian's Signature Print Name Date

Northern Vermont Field Hockey Club Health Form

**CAMPER'S NAME** ____________________

*This form must be completed by the athlete's legal guardian before participation at the camp. Please answer all of the questions, this form will be returned to you if it is missing information. Please type or print in black ink and attach any specific recommendations from your physician to this form.*

**DOES THE ATHLETE 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 (inc. dosage and time of day): ____________________

____________________

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

Will your child require any specific treatment for a medical/emotional condition while participating in our camp? Yes / No

If yes, please explain ____________________

____________________

**MEDICAL HISTORY**

Immunization Dates: Measles____________________ Mumps ____________________

Rubella ______________ OR MMR ____________________ Last Tetanus ____________________ (DPT, TT, or TD)

Polio Series completed____________________

Date of last medical check-up ______________ Reasons for any hospitalization in past 5 years ______________

____________________

____________________

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

Physician's Name____________________ Phone ____________________

Address ____________________

City/State/Zip ____________________

*I have examined the above named athlete and found them to be able to participate in all activities for the Northern Vermont Field Hockey Club.*

____________________ ____________________ ____________________

Physicians Signature Print Name Date