

# ELITE FUTBOL CAMP

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## MEDICAL AND IMMUNIZATION HISTORY PROGRAMS AND CAMPS

Please return form to program: \_\_\_\_\_  
\_\_\_\_\_

Participant name (print): \_\_\_\_\_  
Last First M.I.

### SECTION 1 *(To be completed by parent or guardian.)*

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Month / Day / Year

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Program name: \_\_\_\_\_ Program dates: \_\_\_\_\_

Father: \_\_\_\_\_ Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

Mother: \_\_\_\_\_ Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

Guardian is:  father  mother  other (name and address): \_\_\_\_\_  
(phone number): \_\_\_\_\_

Emergency contact (name, phone number, relationship to participant): \_\_\_\_\_  
\_\_\_\_\_

Family physician name and address: \_\_\_\_\_  
phone number: \_\_\_\_\_

Family dentist name and address: \_\_\_\_\_  
phone number: \_\_\_\_\_

Medical insurance company: \_\_\_\_\_ Policy number: \_\_\_\_\_

In case of medical emergency, I hereby give permission to University Health Services (UHS) staff to hospitalize,  
to secure proper treatment for, and to order injection or minor surgery for my child, as named above.

\_\_\_\_\_ Date

\_\_\_\_\_ Parent/guardian signature

### SECTION 2 **PHYSICAL EXAMINATION:** *Must have been done by a medical provider within the preceding 12 months.*

#### MEDICAL HISTORY (please note significant disorders):

Allergies: \_\_\_\_\_ Heart: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_

\_\_\_\_\_ Kidney: \_\_\_\_\_ Whooping Cough: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Lung: \_\_\_\_\_ Varicella: \_\_\_\_\_

Neurological: \_\_\_\_\_ Disabilities: \_\_\_\_\_ Other: \_\_\_\_\_

Pertinent medical history:

Summary of significant treatment program, including names and doses of medications to be used while at program  
(medications MUST be in a container with the original label):

Participant name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**SECTION 3 REQUIRED IMMUNIZATIONS**

**MEASLES, MUMPS AND RUBELLA (MMR) VACCINE**

First dose must be after age 12 months; 2 doses required.

MMR #1 \_\_\_/\_\_\_/\_\_\_ MMR #2 \_\_\_/\_\_\_/\_\_\_

**POLIO VACCINE**

Dates: \_\_\_/\_\_\_/\_\_\_

A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mix of (IVP/OPV) was used, four doses are required.

\_\_\_/\_\_\_/\_\_\_

\_\_\_/\_\_\_/\_\_\_

Completed primary series of polio immunizations?  YES  NO

\_\_\_/\_\_\_/\_\_\_

**DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE**

Minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all campers and staff who will be entering grades seven through 10. For campers and staff who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.)

Completed primary series of DTaP/DTP/DT?  YES  NO

Dates: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_ Date last Td \_\_\_/\_\_\_/\_\_\_

**HEPATITIS B**

Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

Dose # 1 \_\_\_/\_\_\_/\_\_\_ Dose #2 \_\_\_/\_\_\_/\_\_\_ Dose #3 \_\_\_/\_\_\_/\_\_\_

**EXCEPTIONS**

- **RELIGIOUS OBJECTION:** The individual must submit a written statement, signed by a parent/guardian if a minor, to the effect that the individual is in good health and stating the reason for such objections.
- **MEDICAL:** The individual must submit certification by a physician stating that the physical condition of the individual is such that his or her health would be endangered by such immunization.

Health care provider signature and/or stamp: \_\_\_\_\_

Printed name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Date: \_\_\_\_\_