Massachusetts Dept. of Health REQUIRES the following information. THIS IS MANDATORY!

In accordance with the 105 CMR 430.160 of the MA Dept. of Health

Camp Code _____

BU MEN'S ICE HOCKEY

MEDICAL INFORMATION FORM

(Print Clearly) *(Print Clearly)*

FULL NAME: _____ D.O.B.: _____ _____

ADDRESS: _____ Male: ☐ Female: ☐

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: Home # _ __ Work # _

CELL PHONE: Dad # _____ Mom # _____

MANDATORY: Please attach a copy of this year's school physical (it has all of your child's immunizations and your Doctor's signature).

IMMUNIZATIONS: *(Dates for each dose.)*	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Hep B					
DTP/DT/DTaP	_____	_____	_____	_____	_____
Td	_____	_____			
OPV/IPV	_____	_____	_____	_____	
MMR	_____	_____			
Varicella	_____	_____		☐ Chicken Pox: Age: _____ *(Please check)*	

Weight: __ _____ Height: __ _____ _____ BP: _____

Yes	No	*(Please Check If Applicable)*
☐	☐	**Asthma**: ☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced
☐	☐	**Allergies**: ☐ Medication ☐ Food ☐ Seasonal ☐ Other ____ _____
☐	☐	**Anaphylactic Reaction**: ☐ Insect ☐ Food ☐ Latex
☐	☐	**EPI Pen/EPI Pen Jr.**: If YES, please include a doctors order stating emergency use of pen.
☐	☐	**Diabetes**: ☐ Type I ☐ Type II
☐	☐	**Seizure Disorder**

(Please Check)

Restrictions: The following restrictions apply to this individual -

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Other (*describe*)

_____

General Health History that applies to this individual

	Yes	No		Yes	No
Any recent injury, illness or infectious disease?	☐	☐	Ever been diagnosed with a heart murmur?	☐	☐
Have a chronic or recurring illness?	☐	☐	Ever had back problems?	☐	☐
Ever been hospitalized?	☐	☐	Ever had problem with joints? (i.e. knee, ankle)	☐	☐
Ever had surgery?	☐	☐	Have an orthopedic appliance for camp?	☐	☐
Have frequent headaches?	☐	☐	Have any skin problems? (i.e. acne, rash)	☐	☐
Ever have a head injury?	☐	☐	Had mononucleosis in the past 12 months?	☐	☐
Ever been knocked unconscious?	☐	☐	Had problems with diarrhea/constipation?	☐	☐
Wear glasses, contacts?	☐	☐	Have problems with sleepwalking?	☐	☐
Ever had frequent ear infections?	☐	☐	Have a history of bed-wetting?	☐	☐
Ever passed out during or after exercise?	☐	☐	Ever had an eating disorder?	☐	☐
Ever been dizzy during or after exercise?	☐	☐	Ever had emotional difficulties for which Professional help was sought?	☐	☐
Ever had seizures?	☐	☐			
Ever had chest pains during or after exercise?	☐	☐			
Ever had high blood pressure?	☐	☐			

Please explain any "YES" answers on next page.

Explanation of "YES" answers from previous page. _____

_____

_____

I have examined this patient and in addition, the health history and immunization records have been reviewed. There are no apparent contraindications to participating in routine hockey camp activities.

Date of Last Physical: _____ Physician's Name: _____

Physician's Address: _____

Physician's Telephone #: _____

Today's Exam Date: _____ → _____

Physician's Signature

The Parent/Guardian by his/her signature denies that any significant health problems have occurred ***since the above date.***

Today's Date: _____ → _____

Parent/Guardian Signature

CONSENT TO TREAT

I grant to medical personnel o BU Men's Ice Hockey *g permission to provide medical care for conditions, which arise during participation in the* BU Men's Ice Hockey *. Every effort will be made to contact parents for specific permission if general anesthetic is indicated. I hereby authorize the administration of whatever medical or surgical treatment may, in the judgment of the physician, be necessary and advisable for my chil* BU Men's Ice Hockey *is not responsible for participants who arrive sick or injured. (See Policy Letter)*

→ _____

(Child's Name)

_____ ← → _____

(Parent or Guardian Signature) (Date)

Is there anything else you think might be helpful to us in caring for this player. If yes, please attach an explanatory letter.

PLEASE NOTIFY US IF ANY MEDICAL TREATMENT OR PROGRAM WILL CONTINUE DURING THIS STAY.

Required

MUST BE FILLED OUT

EMERGENCY INFORMATION: (If parents cannot be reached)

NAME: _____ RELATIONSHIP: _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: # _____ EMAIL ADDRESS: _____

Required

MUST BE FILLED OUT

INSURANCE INFORMATION:

Policy Holder: _____ Policy Holder D.O.B.: _____

Policy Holder Social Security # _____ - _____ - _____

Company Policy is held with: _____

PO Box # and address of Insurance Company: _____

800 # of Insurance Company: _____

Additional Information: _____

In accordance with the 105 CMR 430.160 of the MA Dept. of Health

Administration of Prescription + Non-Prescription Medication to a Camper or Staff Member

In accordance with the 105 CMR 430.160 of the MA Dept. of Health

(To be completed by Parent/Guardian)

Camp Code # _____

NAME OF CAMPER: _____

NAME OF PARENT/GUARDIAN: _____

TELEPHONE: Home # __ _ Work # __ _

CELL PHONE: Dad # _____ Mom # _____

EMERGENCY #: _____ NAME _____

FOOD/DRUG ALLERGIES: _____

Please list ALL medications (including over-the-counter or non prescription drug) taken routinely. Bring enough medication to last the entire time at camp. Keep original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration

Yes ☐ No ☐

Non-Prescription Medication

Allowed to take "**over the counter**" medications during camp stay (Advil, Tylenol, Tums, etc.).

Yes ☐ No ☐

Prescription Medication

Prescription Medications will be taken during camp stay. Please list each drug separately in the boxes below (This includes inhalers/epi pens).

Name of Medication: _____

Dose given at Camp: _____ (i.e. 1x/day, 2x/day) Duration of Order: _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time)

Special Storage Requirements: _____

Name of Medication: _____

Dose given at Camp: _____ (i.e. 1x/day, 2x/day) Duration of Order: _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements: _____

Name of Medication: _____

Dose given at Camp: _____ (i.e. 1x/day, 2x/day) Duration of Order: _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements: _____

→ _____ *Parent/Guardian Signature*

→ _____ *Physician's Signature*