

**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 _____

(Print Clearly)

MEDICAL INFORMATION FORM

(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.)

Hep B

DTP/DT/DTaP

Td

OPV/IPV

MMR

Varicella

Dose 1

Dose 2

Dose 3

Dose 4

Dose 5

☐ 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 doctor's order stating emergency use of pen.

☐ Diabetes: ☐ Type I ☐ Type II

☐ Seizure Disorder

(Please Check)

Restrictions: The following restrictions apply to this individual -

Dietary

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Other (describe) _____ | | |

General Health History that applies to this individual

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

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 of Dynamic Skating permission to provide medical care for conditions, which arise during participation in the Dynamic Skating Hockey School. 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 child. Dynamic Skating 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: _____



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