MEDICAL FORM

According to Massachusetts General Law 105CMR 430.00 ALL CAMPERS MUST SUBMIT, IN COMPLETION, THE HEALTH FORM BELOW

Participant Name (print) _____

Section I: (to be completed by parent/guardian)

Name: _____

Birthdate:_____

Address:_____

City:_____ State_____ Zip_____

Program Name: _____

Program Dates: _____ to _____

Father: _____ Mother: _____

Day Phone: _____ Day Phone: _____

Evening Phone: _____ Evening Phone:_____

Guardian is: Father_____ Mother_____ Other_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

In case of illness or emergency the name and telephone number of a person to contact (relation to participant) _____

Family Physician or HMO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Family Dentist:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical Insurance Company: _____

Policy Number: _____

In case of medical emergency, I hereby give permission to the certified Preseason Position Clinic Athletic Training staff member to hospitalize, to secure proper treatment for, and to order minor injection or minor surgery for my child, as named above.

Signature of parent: _____

New England Hockey Factory
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Section II: Physical Examination (Must be in the preceding 24 months by a Medical Provider)

Child Name: _____
Birthdate: _____
Summary of significant treatment program including name/dose of medications to be used while at program (medication must be in a container with the original label)
Medical History (check significant disorders)
Allergies: _____ Heart: _____ TB: _____
Kidney: _____ Lung: _____ Diabetes: _____
Varicella: _____ Disabilities: _____ Neurological: _____
Whooping Cough: _____ Other: _____
Pertinent Medical History:
_____
_____

Section III: Immunizations
Completed primary series of tetanus/diphtheria? (four doses)
Yes: _____ No: _____
Completed primary series of polio immunizations?
Yes: _____ No: _____
Primary series-Type of Vaccine OPV IPV E-IPV _____/_____/_____
Laser Booster-Type of Vaccine OPV IPV E-IPV _____/_____/_____

IMMUNIZATIONS	**DATES**
Diphtheria/Tetanus (must be within last 10 years)	_____/_____/_____
Measles #1 (must be after age 12 months) (rubeola, red measles)	_____/_____/_____
MMR#1	_____/_____/_____
Or Positive Measles Titer (Blood test)	_____/_____/_____
Measles #2 (must be at least 30 days after first dose) (rubeola, red measles)	_____/_____/_____
Or MMR#2	_____/_____/_____
Mumps or MM#1 (must be after age 12 months)	_____/_____/_____
Or Positive Mumps Titer (blood test)	_____/_____/_____
Rubella (German measles) or MMR#1 (after age 12 mos)	_____/_____/_____
Or Positive Rubella Titer (blood test)	_____/_____/_____

Hepatitis-B (those born after 1-1-92)
Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____
Medical exemption: The above named person does not have one or more of the required immunizations because of a medical problem(s) that precludes the _____ vaccine(s).
Health care provider/physician:
Signature/stamp and date: _____
Printed name: _____
Address: _____City: _____
State: _____Zip: _____ Phone: _____

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