NAME ____________________

BIRTH DATE ________________

SEX ______

AGE ______

Squash & Beyond

SQUASH | CULTURE | LANGUAGE

MEDICAL FORM

PARENT OR GUARDIAN ______________________________

STREET ADDRESS ______________________________

CITY/STATE/ZIP ______________________________

HOME PHONE ________________ WORK PHONE ________________ CELL ________________

SECOND PARENT OR GUARDIAN ______________________________

STREET ADDRESS ______________________________

CITY/STATE/ZIP ______________________________

HOME PHONE ________________ WORK PHONE ________________ CELL ________________

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY: ______________________________

RELATIONSHIP ______________________________

HOME PHONE ________________ WORK PHONE ________________ CELL ________________

NAME OF FAMILY PHYSICIAN: ______________________________PHONE________________

NAME OF DENTIST/ORTHODONTIST: ______________________________PHONE________________

Does the insurance company require preauthorization? YES NO

INSURANCE COMPANY______________________________ POLICY # ________________

BILLING ADDRESS ______________________________

GROUP # ______________________________ PHONE # ______________________________

**** EACH PARTICIPANT IS RESPONSIBLE FOR MEDICAL EXPENSES.**

HEALTH HISTORY (continues on page 2)

Please give approximate dates and explain in space at bottom of page 2 as needed.

Chicken Pox	__________	Bleeding/Clotting Disorders	__________
Measels	__________	Seizures	__________
German Measels	__________	Mononucleosis	__________
Mumps	__________	Knee/ankle problems	__________
Heart Defect/Disease	__________	Neck/back problems	__________
Hypertension	__________	Shoulder/wrist problems	__________
Autoimmune deficiency	__________		

CONTINUING CONDITIONS: Check if current and explain in space at bottom of page 2 as needed.

❒ Rheumatic Fever ❒ Convulsions ❒ Glasses ❒ Other ________________

❒ Heart Disease ❒ Diabetes ❒ Hearing Loss

❒ Ear Infections ❒ Asthma ❒ Contacts

DATE OF LAST PHYSICAL EXAMINATION: ______________________________

Zafi Levy • Williams College, Lasell Gym, 22 Spring Street, Williamstown MA 01267

Ph: 413.597.4627 • Fax: 413.597.4272 • Cell: 413.884.2629 • Email: ZLevy@williams.edu

ALLERGIES: Please list any allergies including medicines, foods, plants, bites, stings, etc.

❒ Insect Stings ❒ Medication(s) ______________________________

❒ Environmental ______________________________

❒ Other ______________________________

MEDICATION: Please list any prescribed medication that is currently taken. Please indicate what will be sent with student to camp, and which (if any) medication will be discontinued during camp.

Medication	Condition	Medication required

**Please send a double supply of all inhalers and other prescription medications with your child for the duration of the trip.

CHILDHOOD ILLNESSES: Please list any allergies including medicines, foods, plants, bites, stings, etc.

❒ Chicken Pox ❒ Measels ❒ Other ______________________________

❒ Rubella ❒ Mumps

IMMUNIZATION HISTORY: Please check and give date of completion, if current.

❒ Tetanus ___/___/___ ❒ Mumps ___/___/___ ❒ Polio ___/___/___ ❒ Tetanus ___/___/___

❒ Rubella ___/___/___ ❒ DPT Series ___/___/___ ❒ Hepatitis B ___/___/___

❒ Chicken Pox (Varicella) ___/___/___ ❒ Haemophilus Influenza Type b ___/___/___ ❒ Meningitis ___/___/___

Has this student ever required any psychiatric counseling or hospitalization? ______________________________

____

Please list any operations or serious injuries (include dates): ______________________________

____

Are there any specific activities to be discouraged or limited by physician's advice? ______________________________

____

Does your child have any specific dietary restraints? ______________________________

____

PLEASE LIST ANY ADDITIONAL INFORMATION/CONCERNS ON THE BACK OF THIS PAGE.

This health history is correct to the best of my knowledge. I believe my child to be physically and emotionally capable of participating in this camp. He/She has my permission to participate in all camp activitiesexcept as noted. I give my permission to Squash and Beyond WORLD and all affiliates (including coaches and staff):

1. To have access to my son/daughter's medical information included on this form.
2. To select medical personnel and to order x-rays, routine tests, or treatment for the participant listed above.
3. To make relevant medical information available to medical personnel.
4. To provide ongoing health care during the Camp.

Emergency Authorization: In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Squash and Beyond WORLD to hospitalize, secure proper treatment for, order injection for and/or anesthesia and/or surgery for the participant named above.

Signature of parent or guardian ______________________________

Witness ______________________________ **Date** ______________

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