

Camp Location: _____ Date of camp: _____



Casey Powell Lacrosse LLC
Health Exam/Record, Insurance, & Authorization

Physical exams are valid for 3 years from date of last examination.

Camper Staff

▶ Last Name First Name Date of Birth Phone Number

▶ Parent/Guardian Address Phone

▶ Emergency Contact Phone Cell Phone

Date of arrival at camp

Departure date

▶ **Insurance Information:** Please provide family medical/hospital insurance information

Carrier or plan name: _____ Group #: _____

▶ **Authorization – This section must be completed by a parent/guardian of participants under 18 years old:**

I, the undersigned, hereby give permission to Casey Powell Lacrosse LLC and its designee to provide and/or seek out required health care for the individual named above in the event such care is necessary. Second, I hereby give Cheshire or Mercersberg Academy and its designee the authority to arrange for transportation as essential in providing appropriate medical care. Third, I hereby authorize Casey Powell Lacrosse LLC and its designee to release related records to the health care provider. Fourth, in the event I cannot be reached, I hereby authorize the physician chosen by Casey Powell Lacrosse LLC and its designee to administer treatment for the individual named above. I also understand that this form will be photocopied for accompaniment on any off-site trips.

Parent signature: _____ Printed: _____ Date: _____

THE FOLLOWING MUST BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

_____ Individual may participate in all activities

Date of Exam: / /

_____ Individual may participate except for: _____

Medical information pertinent to routine care and procedures: _____

Is individual taking prescription or over-the-counter medications(s)? YES NO

If yes, indicate names of medication(s): _____

Does the individual have allergies? YES NO If yes, explain: _____

Is the individual on a special diet? YES NO If yes, explain: _____

Does the individual have special needs? YES NO If yes, explain: _____

This individual is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatric and National Advisory Committee on Immunization Practices:

	YES	NO		YES	NO
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: _____

Print name of medical care provider: _____

Medical Care Provider's address: _____ City: _____ ST: _____ Zip: _____

Signature of Physician, APRN or PA

Date form signed

Phone number