

Pro Star Hockey

Medical Information

Please print clearly with a blue or black pen

Participant's Name: _____ DOB: _____ Sex: _____

Address: _____ State: _____ Country: _____ Zip: _____

Home Phone Number: _____

Age: _____ Entering Grade: _____ School: _____

Height: _____ Weight: _____

Emergency Contact Information

In the event of an emergency, who should the staff contact? Please provide the name and telephone number of the person to call: _____

Mother's Name: _____

Mother's Phone Number: _____

Father's Name: _____

Father's Phone Number: _____

Allergies, Medications, and Special Accommodations

Does the participant have allergies? YES _____ NO _____

If yes, please explain. Specify any medications and if the allergy is environmental or food. _____

Does the participant carry an EPI-PEN? YES _____ NO _____

Does the participant take any medications? YES _____ NO _____

If yes, please provide the following information for each medication the participant is taking:

Name of medication, does, route, time: _____

Reason for taking this medication: _____

Name of medication, does, route, time: _____

Reason for taking this medication: _____

Name of medication, does, route, time: _____

Reason for taking this medication: _____

Does the participant self-administer his/her own medications? YES _____ NO _____

Please sign your name below allowing the participant to self-administer his/her own medication while attending the Pro Star Hockey camp.

Parent's Signature: _____

Please note: If the participant will need the nurse/staff to administer medications, an "Authorization to Administer Medication" form must be completed. This form must be updated for each session.

This program meets the minimum standards for compliance and licensing by the Massachusetts Department of Public Health and the local Health Department.

Has the participant had any surgical procedures in the last sixth months? YES _____ NO _____

If yes, please provide details: _____

Does the participant have any physical limitations? YES _____ NO _____

If yes, please provide details: _____

Does the participant have any learning issues you would like the Pro Star Hockey staff to be aware of?

YES _____ NO _____

If yes, please explain: _____

Does the participant have any medical issues/problems you would like the Pro Star Hockey staff to be aware of? YES _____ NO _____

If yes, please explain: _____

Physical examination

Date of last physical examination _____ (must be within the last two years to attend the camp)

Please attach a copy of the last physical examination.

Required Immunizations

Please attach a copy of the participant's immunization record or provide the following information:

D.T.P. (4 doses) _____

Polio (3 doses) _____

Hepatitis B (3 doses) _____

H.M.R. (2 doses) _____

TD Booster (within 10 years for grades 11 and 12) _____

(within 5 years for grades 7 to 10) _____

Varicella Vaccine or proof of disease (except grade 5) _____

PARENT/GUARDIAN SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____ DATE _____

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