



2130 Providence Highway
Walpole, MA 02081
508-660-3033

MEDICAL INFORMATION FORM

Please fill out completely. Information is mandatory for participation.

Name: _____

Address: _____

City _____ State: _____ ZIP: _____

D. O. B. _____ Male Female: Height: _____ Weight: _____

Telephone (H) # _____ (W) # _____

Cell/ Dad # _____ Cell/Mom # _____

General Health History (Circle all that apply. Provide details below.)

- | | | | |
|---|-----|---|-----|
| Any recent injury, illness or infectious disease? | Y/N | Ever been diagnosed with a heart murmur? | Y/N |
| Have any chronic or recurring illness? | Y/N | Have you ever had an eating disorder? | Y/N |
| Ever been hospitalized? | Y/N | Ever had back or joint problems (e.g. knees)? | Y/N |
| Ever had surgery? | Y/N | Do you use an orthopedic appliance? | Y/N |
| Have frequent headaches? | Y/N | Do you have skin problems? | Y/N |
| Ever had a head injury or been knocked unconscious? | Y/N | Have you had mononucleosis in past 12 months? | Y/N |
| Do you have frequent ear infections? | Y/N | Do you have any sleep-related problems (e.g. sleepwalking)? | Y/N |
| Do you wear glasses or contacts? | Y/N | Have you ever passed out during/after exercise? | Y/N |
| Ever had seizures or high blood pressure? | Y/N | Ever had chest pains during/after exercise? | Y/N |
| Ever sought professional help for emotional difficulties? | Y/N | | |

Provide details for all "yes" answers:



Do you have: (Circle all that apply)

Asthma Mild Moderate Severe Exercise-induced

Allergies Food _____ Medication _____ Other _____

Diabetes Type I Type II

Seizure disorder (describe): _____

Use an EPI Pen/EPI Pen Jr. Yes No

If YES, please attach a doctor's order permitting emergency use of pen.

Dietary restrictions (circle all that apply):

Does not eat red meat Does not eat pork Does not eat eggs

Does not eat poultry Does not eat seafood Does not eat dairy products

Other (describe):

CONSENT TO TREAT

I grant to RB Hockey medical personnel permission to provide medical care for conditions that arise during participation in RB Hockey camps. (Every effort will be made to contact parents/guardians 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.

Child's name _____

Parent/guardian signature _____

Date: _____



AUTHORIZATION AND CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child _____
(Name)

However, if I cannot be reached I hereby authorize **Rob Barletta's Hockey School** to transport my child to the _____ Hospital (or nearest hospital)
(Name) and to secure for my child the necessary medical treatment. I Understand that staff Members at **Rob Barletta's Hockey School** are trained in the basics of First Aid and I Authorize them to give my child first aid when appropriate.

Parent/Guardian Signature Date

.....

EMERGENCY RELEASE FORM

In case of emergency give names of persons who can be called and are authorized to pick-up your child if we cannot reach a parent:

Name _____ Relationship to child _____

Address _____ Tel. No. _____

Name _____ Relationship to child _____

Address _____ Tel No. _____

Parent/Guardian Signature Date

INSURANCE INFORMATION

Policyholder: _____ Policy holder D.O.B.: _____

Policyholder Social Security # _____ - _____ - _____

Insurance company name: _____ Customer service 800#: _____

Insurance company address: _____



IMMUNIZATIONS

(Please provide dates each dose was administered.)

<i>Vaccine</i>			<i>Date</i>
Hepatitis B			1
			2
			3
DTaP	DTP	DT	
			1
			2
			3
			4
			5
IPV	OPV		
			1
			2
			3
			4

<i>Vaccine</i>		<i>Date</i>
Hib		1
		2
		3
		4
MMR		1
		2
Varicella		1
		2
Other:		

Chicken Pox (age)

PHYSICIAN'S RELEASE

I have examined this patient and have reviewed this medical questionnaire. 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: _____



**Administration of Medication
(Prescription and/or Non-Prescription)
to Camper or Staff Member**

In accordance with MA Dept. Health 105 CMR 430.160

(To be completed by parent/guardian)

Food/drug allergies: (List all)

Camper: _____

Parent/guardian: _____

Telephone (H): _____ (W) _____

Cell/Dad: _____ Cell/Mom: _____

Emergency contact: _____

Camp Code # _____

Telephone: _____

MEDICATION

Non-Prescription Medication

Camper/staff is allowed to take non-prescription medication (e.g. Advil, Tylenol) during camp. Yes No

Prescription Medication

Camper/staff requires prescription medication during camp. Yes No

Please list all medications (prescription and over-the-counter) taken routinely:

Please list all medications required during camp. Bring enough medication to last throughout camp. Retain original packaging/bottle identifying prescribing physician (if prescription), name of medication, dosage, and frequency of administration.

Name of medication: _____

Dose given at camp: _____ (i.e. 1x/day, 2x/day) Duration of order: _____

Specific directions (e.g. with meals): _____ Storage requirements: _____



Name of medication: _____

Dose given at camp: _____ (i.e. 1x/day, 2x/day) Duration of order: _____

Specific directions (e.g. with meals) _____ Storage requirements _____

Name of medication: _____

Dose given at camp: _____ (i.e. 1x/day, 2x/day) Duration of order: _____

Specific directions (e.g. with meals) _____ Storage requirements _____

Name of medication: _____

Dose given at camp: _____ (i.e. 1x/day, 2x/day) Duration of order: _____

Specific directions (e.g. with meals) _____ Storage requirements _____

Name of medication: _____

Dose given at camp: _____ (i.e. 1x/day, 2x/day) Duration of order: _____

Specific directions (e.g. with meals) _____ Storage requirements _____

Signature of parent/guardian _____

Date _____