



HEALTH FORM
205 LACROSSE CAMP
ADMINISTRATIVE OFFICE
 P.O. Box 428
 WAYNE, PA 19087-0428
 484-321-2399 (VOICE)
 484-585-1692 (FAX)
 RISINGSENIORS@205LACROSSECAMPS.COM

This form must be completed in FULL, including signature of physician, and returned to 205 Lacrosse Camp at P.O. Box 428, Wayne, PA 19087-0428 no later than June 1, 2010. Campers will NOT BE ALLOWED to participate without the completed medical form.

Position: _____ Camper's Last Name: _____ First: _____

Height: _____ Weight: _____ Sex: _____ Age: _____

I can be reached by phone at: _____ and an emergency/alternative contact person is:
 _____ And can be reached by phone at: _____

Medical History (please circle for "yes")

German measles, measles, mumps, scarlet fever, chicken pox, diabetes, pneumonia

Other: _____

Immunization History
(month/year)

Allergy History
(yes/no)

Drug Reactions
(yes/no)

Small Pox Vaccine _____
 Diptheria _____
 Tetanus Toxioid _____
 Polio Vaccine _____
 Tuberculin Test _____
 Measles _____

Hay Fever _____
 Asthma _____
 Eczema _____
 Hives _____
 Insect Stings _____

Sulpha _____
 Penicillan _____
 Antibiotic _____
 (Type) _____

If medication will be taken during camp, indicate name of drug and dosage:

Please list any pertinent medical information we should have regarding past injuries, past medical history, or suggested physical limitations relating directly to the participant's ability to participate in the camp for six or more hours per day: _____

I certify that the above-named individual is able to participate fully in the above-named activity, based on physical examination within 12 months prior to said camp date.

 (Signature of Physician) (date)

 (Street Address) (City) (State) (Zip)