Massachusetts Crease LLC

23 Hamilton Street Abington, MA 02351
(781) 412-4030

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 HOME: _____ TELEPHONE WORK: _____

CELL PHONE DAD: _____ CELL PHONE MOM: _____

GENERAL HEALTH HISTORY (CLICK ALL THAT APPLY. PROVIDE DETAILS BELOW.)

Any recent injury, illness or infectious disease? ☑ Y ☐ N

Have any chronic or recurring illness? ☐ Y ☐ N

Ever been hospitalized? ☐ Y ☐ N

Ever had surgery? ☐ Y ☐ N

Have frequent headaches? ☐ Y ☐ N

Ever had any head injury or been knocked unconsious? ☐ Y ☐ N

Do you have frequent ear infections? ☐ Y ☐ N

Do you wear glasses or contacts? ☐ Y ☐ N

Ever had seizures or high blood pressure? ☐ Y ☐ N

Ever sought professional help for emotional difficulties? ☐ Y ☐ N

Ever been diagnosed with a heart murmur? ☐ Y ☐ N

Have you ever had an eating disorder? ☐ Y ☐ N

Ever had back or joint problems (e.g. knees)? ☐ Y ☐ N

Do you use an orthopedic appliance? ☐ Y ☐ N

Do you have skin problems? ☐ Y ☐ N

Have you had mononucleosis in past 12 months? ☐ Y ☐ N

Have you ever passed out during/after exercise? ☐ Y ☐ N

Ever had chest pains during/after exercise? ☐ Y ☐ N

PROVIDE DETAILS FOR ALL "YES" ANSWERS:

_____

_____

_____

DO YOU HAVE (CLICK ALL THAT APPLY AND OFFER DESCRIPTION):

ASTHMA MILD MODERATE SEVERE EXERCISE-INDUCED

DESCRIBE: _____

ALLERGIES FOOD MEDICATION OTHER

DESCRIBE: _____

DIABETES TYPE I TYPE II

SEIZURE DISORDER (DESCRIBE): _____

USE AN EPI PEN/EPI PEN JR.? **Y** ☐ **N** ☐
IF YES, PLEASE ATTACH A DOCTOR'S ORDER PERMITTING EMERGENCY USE OF PEN.

DIETARY RESTRICTIONS (CLICK 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

OTHER (DESCRIBE):

_____

_____

_____

CONSENT TO TREAT

I GRANT TO MASSACHUSETTS CREASE LLC MEDICAL PERSONNEL PERMISSION TO PROVIDE MEDICAL CARE FOR CONDITIONS THAT ARISE DURING PARTICIPATION IN MASSACHUSETTS CREASE LLC GOALTENDING 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 JUDGEMENT OF THE PHYSICIAN, BE NECESSARY AND ADVISABLE FOR MY CHILD.

CHILD'S NAME: _____

PARENT/GUARDIAN 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 LAST NAME, FIRST NAME. HOWEVER, IF I CANNOT BE REACHED I HEREBY AUTHORIZE **MASSACHUSETTS CREASE LLC** TO TRANSPORT MY CHILD TO THE HOSPITAL NAME HOSPITAL (OR NEAREST HOSPITAL) AND TO SECURE FOR MY CHILD THE NECESSARY MEDICAL TREATMENT. I UN DERSTAND THAT STAFF MEMBERS AT **MASSACHUSETTS CREASE LLC** ARE TRAINED IN THE BASICS OF FIRST AID AND I AUTHORIZE THEM TO GIVE MY CHILD FIRST AID WHEN APPRO PRIATE.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

EMERGENCY RELEASE FORM

IN CASE OF EMERGENCY GIVE NAMES OF PERSONS WHO CAN BE CALLED AND ARE AU-THORIZED TO PICK-UP YOUR CHILD IF WE CANNOT REACH A PARENT:

NAME: _____RELATIONSHIP TO CHILD: _____

ADDRESS: _____ TELEPHONE #: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____ TELEPHONE #: _____

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

INSURANCE INFORMATION

POLICYHOLDER: _____ POLICY HOLDER D.O.B: _____

POLICYHOLDER SOCIAL SECURITY NUMBER: _____ - _____ - _____

INSURANCE COMPANY NAME: _____

CUSTOMER SERVICE 800 NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

ADMINISTRATION OF MEDICATION

(PRESCRIPTION AND/OR NON-PRESCRIPTION)
TO CAMPER OR STAFF MEMBER
IN ACCORDANCE WITH MA DEPARTMENT OF HEALTH 105 CMR 430.160

TO BE COMPLETED BY PARENT/GUARDIAN

CAMPER NAME: _____ CAMP CODE #: _____

PARENT/GUARDIAN NAME: _____

TELEPHONE HOME: _____ TELEPHONE WORK: _____

CELL PHONE DAD: _____ CELL PHONE MOM: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT TELEPHONE #: _____

FOOD/DRUG ALLERGIES (LIST ALL): _____

_____

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 THE 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 REQ: _____

MEDICATION CONTINUED

NAME OF MEDICATION: ____

DOSE GIVEN AT CAMP: ____________ (i.e. 1X/DAY, 2X/DAY) DURATION OF ORDER: _________

SPECIFIC DIRECTIONS: (e.g. WITH MEALS): ______________ STORAGE REQ: ______________

NAME OF MEDICATION: ____

DOSE GIVEN AT CAMP: ____________ (i.e. 1X/DAY, 2X/DAY) DURATION OF ORDER: _________

SPECIFIC DIRECTIONS: (e.g. WITH MEALS): ______________ STORAGE REQ: ______________

NAME OF MEDICATION: ____

DOSE GIVEN AT CAMP: ____________ (i.e. 1X/DAY, 2X/DAY) DURATION OF ORDER: _________

SPECIFIC DIRECTIONS: (e.g. WITH MEALS): ______________ STORAGE REQ: ______________

NAME OF MEDICATION: ____

DOSE GIVEN AT CAMP: ____________ (i.e. 1X/DAY, 2X/DAY) DURATION OF ORDER: _________

SPECIFIC DIRECTIONS: (e.g. WITH MEALS): ______________ STORAGE REQ: ______________

NAME OF PARENT/GUARDIAN (PRINT): ____

SIGNATURE OF PARENT/GUARDIAN: ____

DATE: ____________________________________