

Massachusetts Crease LLC

66 Blossom Road, Braintree, MA 02184
(781) 848-1542

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 (CIRCLE ALL THAT APPLY. PROVIDE DETAILS BELOW.)

Any recent injury, illness or infectious disease? Y N Ever sought professional help for emotional difficulties? Y N

Have any chronic or recurring illness? Y N Ever been diagnosed with a heart murmur? Y N

Ever been hospitalized? Y N Have you ever had an eating disorder? Y N

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

Have frequent headaches? Y N Do you use an orthopedic appliance? Y N

Ever had any head injury or been knocked unconscious? Y N Do you have skin problems? Y N

Do you have frequent ear infections? Y N Have you had mononucleosis in past 12 months? 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

PROVIDE DETAILS FOR ALL "YES" ANSWERS:

DO YOU HAVE (CIRCLE 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 (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

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 UNDERSTAND 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 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: _____ 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: _____

IMMUNIZATIONS

(PLEASE PROVIDE DATES EACH DOSE WAS ADMINISTERED)

VACCINE		DATE
HEPATITIS B	1	
	2	
	3	
DTaP DTP DT	1	
	2	
	3	
	4	
	5	
IPV OPV	1	
	2	
	3	
	4	

VACCINE		DATE
Hib	1	
	2	
	3	
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 PHONE #: _____ TODAY'S EXAM DATE: _____

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: _____