



Complete form and mail with registration and deposit to:

Crimson Field Hockey Camp

P.O. Box 382032

Cambridge, MA 02238-2032

This form **MUST** be on file with complete signatures to assure full participation

Last Name _____ First Name _____ DOB _____

Health Insurance Company _____ Membership Number _____

Emergency Contact _____ Phone Number _____

APPLICANT HAS HAD (dates MUST be provided)

	DISEASE	VACCINATION	IMMUNIZATION
Measles	_____	_____	(if born after 1/1/92)
Hepatitis B	_____	_____	
Mumps	_____	_____	
Whooping Cough	_____	_____	
Chicken Pox	_____	_____	
Tetanus	_____	_____	
Diphtheria	_____	_____	
Polio	_____	_____	
TB Test	_____	_____	

PLEASE CHECK APPLICANT'S HEALTH PROBLEMS (PAST OR PRESENT) AND GIVE THE YEAR

Have you ever had, or do you now have, any of the following?

General	Yes	No	Briefly Explain
Asthma	_____	_____	_____
Tuberculosis	_____	_____	_____
Polio	_____	_____	_____
Diabetes	_____	_____	_____
Allergies			
Medications	_____	_____	_____
Food	_____	_____	_____
Bee Stings	_____	_____	_____
Fungus	_____	_____	_____
Herpes	_____	_____	_____
Staph (Boils)	_____	_____	_____
Cyst or Lumps	_____	_____	_____
Spleen Injury	_____	_____	_____
Contact Lenses	_____	_____	_____

Are you taking any medications, prescribed or otherwise? ___Yes ___No

If yes, please explain _____

Neurological	Yes	No	Briefly Explain
Head Injury			
Concussion	_____	_____	_____
Nose Fracture	_____	_____	_____
Neck Injury	_____	_____	_____
Heat Problems	_____	_____	_____

Cardiopulmonary	Yes	No	Briefly Explain
Chest Pains	_____	_____	_____
Palpitations	_____	_____	_____
Shortness of Breath	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Murmur	_____	_____	_____
Fainting	_____	_____	_____

Orthopedic	Yes	No	Briefly Explain
Foot/Ankle	_____	_____	_____
Lower Leg/Knee	_____	_____	_____
Thigh/Hip/Groin	_____	_____	_____
Back/Ribs	_____	_____	_____
Neck/Shoulder	_____	_____	_____
Arm/Elbow/Wrist	_____	_____	_____
Hand/Fingers	_____	_____	_____
Other	_____	_____	_____

Please list any other pertinent medical history _____

Attending Physician _____

Current Vitals
 Height _____ Weight _____ Pulse _____ Blood Pressure _____

The above named individual has received a pre-participation physical examination for her general health and is cleared for activity in Crimson Field Hockey Camps.

Physician Signature _____ **Date** _____

Physician Address _____

Physician Phone _____

Participant The responses to the questions on this form are correct to the best of my knowledge.

Participant Signature _____ **Date** _____

Parent/Guardian I understand and accept that risk of injury is possible while playing or practicing the sport of field hockey. I authorize the directors to act for me according to their best judgment in any emergency requiring medical attention.

Parent/Guardian Signature _____ **Date** _____