

Health Form 2011 Groovy Girls Lacrosse Camp

Student Name:		D.O.B/Grade:	
Parent/Guardian:		Parent/Guardian:	
Street Address:		Street Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	
Other/Message Phone:		Other/Message Phone:	

Emergency Contact:			
Relationship:		Home Phone:	
Work Phone:		Other Phone:	
Family Physician:		Physician's Phone:	
Insurance Company:			
Subscriber's Name:		Policy/Group No.:	

Medical Information	No	Yes	Details (additional space below)
Does your child have asthma?			
Does your child have inhaler?			
Does your child have epilepsy?			
Does your child have diabetes?			
Does your child have any food allergies?			
Does your child have any drug allergies?			
Does your child have a bee sting allergy?			
Does your child require epinephrine?			
Does your child have any other allergies?			

Please list *all* medications used by your child:

Please describe any other health or medical issues that may affect your child:

Parent/Guardian signature

Date