

# Health Form

## ELIZABETHTOWN COLLEGE BOY'S LACROSSE CAMP

**This form must be filled out and returned prior to July 6, 2008 to the address below or brought to registration. No one will be allowed to participate in camp or stay overnight in the dorms until they have submitted the completed Health Assessment Form signed by their parent or guardian and physician. A physical examination must have been performed within the past year.**

Hand carry forms to check-in if they cannot be completed and received by July 6, 2008.

Camper's Last Name: \_\_\_\_\_ First: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Medical History (please circle for "yes")

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

Other: \_\_\_\_\_

Immunization History Allergy History Drug Reactions

(Month/year) (yes/no) (yes/no)

Small Pox Vaccine \_\_\_\_\_ Hay Fever \_\_\_\_\_ Sulpha \_\_\_\_\_

Diphtheria \_\_\_\_\_ Asthma \_\_\_\_\_ Penicillin \_\_\_\_\_

Tetanus Toxoid \_\_\_\_\_ Eczema \_\_\_\_\_ Antibiotic \_\_\_\_\_

Polio Vaccine \_\_\_\_\_ Hives \_\_\_\_\_ (Type) \_\_\_\_\_

Tuberculin Test \_\_\_\_\_ Insect Stings \_\_\_\_\_

Measles \_\_\_\_\_

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)

Return to:

Terry Corcoran

Lacrosse Office

Elizabethtown College

One Alpha Drive

Elizabethtown, PA 17022