# Townshend Hockey Skating Systems Gorham Maine USM Location

**Camp Start Date:** _____ **Camp End Date:** _____
**PLEASE COMPLETE ENTIRE FORM!**

**Student Name (print)** _____
**Age** _____ **Birth Date:** __/____/_____ **Gender:** M F
**Address:** _____
**City**_____ **State:** _____ **Zip:** _____
**Phone Number (Day):** (_____) _____
**(Eve):** (_____) _____
**In Case of Emergency:**
**Contact:** _____**Relationship:** _____
**Phone:** (_____) _____

**Parent/Guardian Authorizations:** This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to THSS to provide routine healthcare and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the THSS to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of THSS or their designee to secure and administer treatment, including hospitalization, for the student named above.

**Indemnification:** The undersigned parent/guardian of the registrant, for and in further consideration of THSS accepting said registrant, hereby agrees to save and indemnify and keep harmless the said THSS, the individual members, employees, staff, faculty, agents, representatives, and officers from and against any claims, judgments, or demands which I, any other parent or guardian, the student, or any other person might make for any losses, damages, personal, mental, or physical injuries against any and all liability, arising as a result of any course of instruction or activity given the registrant by THSS. This release and assumption of risk shall bind myself, my heirs, my assigns, and my personal representatives.

**Signature of Parent/Guardian** _____

**Printed Name** _____**Date** _____

**Medical Insurance Company (REQUIRED)**
**Ins. Co.** _____
**Policy #** _____**Group #** _____
Insured Employer _____
**We recommend that a photocopy (front and back) of health insurance card be attached to this form.**

## Health History:

| **Check those that apply:** | | **Life Threatening Conditions** |
|---|---|---|
| • Contact Lenses | • Ear Aches / Infection | • Asthma |
| • Gyn Problems | • Poison Ivy, Oak, Sumac | • Diabetes |
| • Rheumatic Fever | • Stomach Problems | • Epilepsy / Seizures |
| • Sore Throat | • Absence of a paired organ | • Heart Conditions / Murmur |
| • Whooping Cough | • Sinus Problems | • Food Allergies (specify) |
| • Current orthodontic appliance | • Mononucleosis in the past 12 months | • Medication Allergies (specify) |
| • Skin Problems (Acne, Eczema) | • Recent Illness / Infections | • Other Allergies ~ insect stings, hay fever, animal |
| • HBP | • Concussion / Head Injury | • Other (Please detail) |
| • Bone / Joint Injuries | • Other Chronic Condition | |
| • Operations | • Other | |

*** * * Details of above to be completed on additional sheet * * ***

**Immunization and Physical form from school / physician may be submitted in lieu of completing the immunization and physical examination section below (physicals must be dated within the past two years).**

## Immunizations

| Immunizations | Date | Boosters | | |
|---|---|---|---|---|
| Dtap/TD/Tdap | | | | |
| Polio (3) | | | | |
| Hepatitis B (3) | | | | |
| MMR (2) | | | | |
| TD (valid 10 y) | | | | |
| Haemophilus Influenza Type B | | | | |

| Immunizations or proof of illness | | Date |
|---|---|---|
| Varicela or proof of Chicken Pox | | |

| Illness (if applicable) | | Date |
|---|---|---|
| Measles | | |
| German measles | | |
| Mumps | | |
| Hepatitis A | | |
| Hepatitis C | | |

**Physical Examination: - Valid for Two Years Only and to Be Completed by a Licensed Health Care Professional ONLY!**

| | | | |
|---|---|---|---|
| Height | | Weight | |
| Hearing (R / L) | | Vision (R / L) | |
| Dental / Bite | | Respiratory | |
| Cardiac | | BP | |
| Hernia | | Extremities | |
| Genitals | | Skin | |

**RESTRICTIONS, LIMITATIONS (INCLUDING DIET):**

**RECOMMENDATIONS:**
The above named person is in satisfactory condition and may engage in all camp activities except as noted:

Date: _____ Examining physician: _____
Telephone: (_____)
Print physician's name: _____ State licensed in: __
License #: _____Address: _____

**Student Name (print)** _____

Please fax to 207-510-8024 or e:mail to TownshendHockey@yahoo.com

**Student Name (print)** _____

The following form must be completed and signed by the child's physician if your child:

- Needs to take any routine Over the Counter Medications, provided by the parent/guardian, while at camp.
- Needs to take any routine Prescription Medications, provided by the parent /guardian, while at camp.

## All Medications (Prescription and Over-the-Counter)

Please complete with the camper's current regimen for both **Prescription and Over-the-Counter** medications (i.e. antibiotics, asthma inhalers, allergies, etc.).

**This person takes NO medications on a routine basis.**

| Drug Name | Route | Dosage | Physician Order / Regimen | Comments |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### The following information to be completed by the camper's health care provider:

**Camper's Health Care Provider Name:** _____

**Phone #**: _____

**Address:** _____

**License #:** _____

**Physician's Signature:** _____

**Date:** _____

Parent / Guardian's Signature: _____

Date : _____