

# Townshend Hockey Skating Systems (THSS)

Camp Start Date: \_\_\_\_\_ Camp End Date: \_\_\_\_\_

**PLEASE COMPLETE ENTIRE FORM!**

Student Name (print) \_\_\_\_\_

Age at camp \_\_\_\_\_ 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 \*\*\*

**Individualized Order Form for ALL medications MUST also be completed.**

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**  
**and also bring original to camp:**

**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.**

<b>Drug Name</b>	<b>Route</b>	<b>Dosage</b>	<b>Physician Order / Regimen</b>	<b>Comments</b>

**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 : \_\_\_\_\_