Bob Smith Soccer Camp
Medical History Form

Camper Name **Date of Birth**

1. Immunizations: Please indicate exact date (month, day, year)

DPT or Td:	Polio (IPV):	HIB:	MMR:	HepB:	Tuberculin:
1. _____	1. _____	_____	_____	_____	Year _____
2. _____	2. _____	_____	_____	_____	Type _____
3. _____	3. _____	_____	_____	_____	Result _____
4. _____	4. _____	_____	Measles _____	Other: _____	BCG: _____
5. _____	5. _____		Mumps ___ _____	Chicken Pox: _____	
			Rubella _____		_____

2. Pupil's Medical Health History (please indicate date):

Conditions requiring medical attention

	Camper	Medical Attention	Family History
Pnemeumatic Fever:	_____	_____	_____
Tuberculosis:	_____	_____	_____
Asthma:	_____	_____	_____
Diabetes:	_____	_____	_____
Heart Disease:	_____	_____	_____
Sickle Cell Anemia:	_____	_____	_____
Hypertension:	_____	_____	_____
Chicken Pox:	_____	_____	_____
Ear Infections:	_____	_____	_____
Operations:	_____	_____	_____
Significant Allergies:	_____	_____	_____
Other:	_____	_____	_____

History of Surgery

Restrictions

Allergies and Immediate Treatment Info

Recommendations

Physician name and phone number

Parents Emergency Contact Numbers

Submit Medical Form Via Email