

IFS MEDICAL FORM

*Must complete pages 1 & 2

*Parent signature required

Return to:
International Futbol Sports (IFS)
PO Box 509
Lake Harmony, PA 18624

Return hard copy form ASAP or by July 1st
Check Session(s):
Delaware Valley University

July 19 – 21, 2027

- ☐ Varsity Half Day Camp
☐ Youth Half Day Camp

July 29 – 31, 2027

- ☐ DeSales Boys' Residential Camp



CHILD'S NAME _____ BIRTH DATE _____ SEX _____ AGE _____

Last First Middle

HOME ADDRESS _____

Street

City

State

Zip

HOME PHONE # _____ Parent email: _____

PARENT/ GUARDIAN NAME(S):

MOTHER _____ FATHER _____

MOTHER - WORK # _____ FATHER WORK # _____

MOTHER - CELL # _____ FATHER CELL # _____

IF PARENT(S)/ GUARDIAN NOT AVAILABLE IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME _____ NAME _____

ADDRESS _____ ADDRESS _____

PHONE # _____ PHONE # _____

RELATIONSHIP _____ RELATIONSHIP _____

HEALTH HISTORY: (Check, giving approximate dates)

Frequent Ear Infections _____
 Heart Defect/Disease _____
 Convulsions _____
 Diabetes _____
 Bleeding/Clotting Disorders _____
 Hypertension _____
 Psychiatric Treatment/
 Counseling _____

Diseases
 Chicken Pox _____
 Measles _____
 German Measles _____
 Mumps _____
 Mononucleosis _____

Allergies
 Asthma _____
 Hay Fever _____
 Seasonal _____
 Ivy Poisoning _____
 Insect Stings _____
 Bee Stings _____
 Penicillin _____

Food
 Nut _____
 Other _____

Carries Epipen? _____
 Other drugs _____

Operations or serious injuries _____

Disability or chronic recurring illness / injury _____

Any specific activities to be encouraged or limited by physician's advice _____

*Current Medications (send with instructions) _____

Other diseases or details of above _____

Dietary Modifications _____

Name of Family Physician _____ Phone # _____

Name of Dentist / Orthodontist _____ Phone # _____

HEALTH INSURANCE INFORMATION

COMPANY NAME: _____ POLICY # _____

Suggestions or health related information for camp personnel _____

*Important – MUST be completed and signed for attendance: This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp: 1.To provide ongoing health care. 2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above. Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp. Camper agrees to abide with any restrictions placed on his/her activities.

Signature of Parent/ Guardian X _____ Date _____

← PARENT/GUARDIAN
SIGNATURE REQUIRED

The applicant is CURRENTLY UNDER THE CARE OF A PHYSICIAN for the following condition(s): (PRINT CLEARLY)

CURRENT TREATMENT / Include MEDICATIONS _____

Explanation of any reported loss of CONSCIOUSNESS, CONVULSION OR CONCUSSION DATES: _____

Does applicant have EPILEPSY? YES _____ NO _____ Does applicant have DIABETES? YES _____ NO _____

RECOMMENDATIONS and/or RESTRICTIONS WHILE PARTICIPATING: _____

Any MEDICATION to be administered (specific dosages):

Any ALLERGIES (foods, drugs, plants, insects, etc.):

ADDITIONAL HEALTH INFORMATION: