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 22 – 25 *
□ Varsity Camp Full Day
□ Youth Camp Half Day

July 7 – 10
□ Residential Camp

**Fri Jul 26 inclement weather make-up day if necessary*

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)

		Diseases		Allergies		Food	
Frequent Ear Infections	_____	Chicken Pox	_____	Asthma	_____	Nut	_____
Heart Defect/Disease	_____	Measles	_____	Hay Fever	_____	Other	_____
Convulsions	_____	German Measles	_____	Seasonal	_____		_____
Diabetes	_____	Mumps	_____	Ivy Poisoning	_____		
Bleeding/Clotting Disorders	_____	Mononucleosis	_____	Insect Stings	_____		
Hypertension	_____			Bee Stings	_____	Carries Epipen?	____
Psychiatric Treatment/ Counseling	_____			Penicillin	_____	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: