PLAYER PROFILE FORM

Please bring this form to "check-in" on the first day of camp. This form **must** be brought with you to "check-in" along with your medical form on your first day of camp.

Camp Session: _____ ++++++++++++++++++

Name: _____ + +

Birth Date: _____ Age at Camp: _____ ATTACH PHOTO HERE

Height: _____ Weight: _____ + +

Vertical Jump (if known): _____ ++++++++++++++++++

Camps attended in the past and when: _____

# of Years, Soccer playing experience: _____ Position most played: _____

Brief experience of soccer playing experience (include school and play): _____

_____

_____

The goals and objectives you hope to achieve throught attendance at No.1 Soccer Camps:

_____

_____

Special concerns/situations that No.1 Soccer Camps should be aware of: _____

_____

_____

_____

Youth Camp Health Exam/Record

No. 1 Soccer Camps • Medical Form

Please bring this form to "check-in" on the first day of camp.

www.no1soccercamps.com

Campsite and Dates Attending: _____

Last Name: _____ First Name: _____ Age: _____ Birth date: _____

Social Security Number (of camper) _____

Address: _____

City/State/Postal Code: _____

Name of Parent or Guardian: _____Telephone: _____

Emergency Contact: _____ Telephone: _____

Date of Arrival at Camp: _____Departure Date: _____

Date of Exam: _____ Height: _____ Weight: _____

Identify any known medical or emotional illness or disorder that would currently pose a risk to others or which would currently affect the individual's functional ability to participate safely: _____

_____

Medical information pertinent to routine care and emergencies: _____

_____

Is this individual taking prescription medication? ❍ YES ❍ NO

If yes, indicate prescription: _____

Does the individual have allergies? ❍ YES ❍ NO Explain: _____

Is the individual on a special diet? ❍ YES ❍ NO Explain: _____

Can the individual self-administer medication? ❍ YES ❍ NO Explain: _____

IMMUNIZATION RECORD: (month, day, year for each dose)

Immunization	**Date**	**Date**	**Date**	**Date**	**Date**	**Immunization**	**Date**
	1st dose	2nd dose	3rd dose	4th dose	5th dose		
DTP/DtaP/DT						MMR (1ST dose)	
OPV/1PV						Measles (2nd dose)	
Hib (Haemophilus Influenza Type B)						Varicella (Chicken Pox) (Recommended)	
Hepatitis B						Other (Specify)	

Are there medical contraindications to immunization? ❍ YES ❍ NO If yes, specify the vaccine(s) and indicate the contraindications specified in the vaccine manufacturers' package insert that applies. _____

_____

Does this individual have laboratory confirmed proof of immunity to natural infection? ❍ YES ❍ NO If yes, please explain and attach laboratory report: _____

Is this individual current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health?

❍ YES ❍ NO Next appointment for Immunizations is scheduled for: _____

Month/Day/Year

Special Attention:

Mononucleosis within two months of camp activity is a contraindication to participation in the program.

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

Medical Care Provider
(Name, Address, Telephone)

_____
Signature of MD, APRN or PA

_____
Date Form Signed

Attention Parent/Guardian:

Campers may not be permitted to participate in camp activities without a medical form signed by both parent/guardian and physician. In addition, campers may be refused medical treatment at local medical care facilities if medical form is not complete, insurance information is not provided and parent/guardian permission has not been granted. Please give these important details your utmost attention.

Medical/Accident Insurance: This form will not be accepted unless the following medical/accident insurance information is completed:

Medical/Accident Insurance Company: _____

Policy Number: _____

Policy Holder: _____

Social Security Number of Policy Holder: _____
(Parent/Guardian)

Employer's Name: _____

Parent/Guardian Authorization: (required for all persons under age 18) This health history is correct so far as I know, and the person named above has my permission to participate in all camp activities except as noted by me or the examining physician. I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and order injection, anesthesia for surgery for the person named above. I hereby authorize the staff at No. 1 Goalkeeper's Camp, Inc. (DBA No. 1 Camps) to act according to their best judgement in an emergency requiring medical attention, and hereby waive and release the Camp and its staff from any and all liability for any injuries incurred while at camp. All medical expenses incurred will be the responsibility of the camper or the camper's parent/guardian. The camp is not responsible for personal items that are lost, stolen or damaged. I understand and accept the No. 1 Camps cancellation and refund policy. In addition, I give permission for my son/daughter to be taken off the campsite for supervised outings (professional soccer games, etc.) and agree that No. 1 Camps may use any photograph or video taken at No. 1 Camps for promotional purposes.

_____ _____
Signature Date

_____
Print Name

No. 1 Soccer Camps at Western Connecticut State University, Danbury, Connecticut, Pomfret School, Pomfret, Connecticut and Northfield Mt. Hermon in Massacusetts

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS
Prescription and Over the Counter

If a Youth Camp chooses to administer medications, the Connecticut & Massachsetts State Law and Regulations require an authorized prescriber (MD, PA, APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: Date: _____
Name of Child _____ Date of Birth _____
Street Address _____ City and State _____
Condition for which drug is being administered during camp hours _____
_____
DRUG: Name of Drug, Dose and Method of Administration _____
Times of Administration: _____ / _____ / _____
Medication shall be administered from _____ (date) to _____ (date)
Relevant side effects to be observed, if any _____
_____
If there are side effects, plan for management _____
_____
Is this a controlled drug? _____
Allergies, reaction to, or negative interaction with food or drugs? If YES, list _____
_____
The authorized prescriber's or Dentist's name _____ Phone: _____
Street Address _____ City and State _____

Authorized Prescriber or Dentist's Signature _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF ABOVE MEDICATION:
Date: _____
I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child _____, to be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following the termination order.

Name of Parent or Guardian _____ Signature _____
Relationship to Child _____ Street Address _____
City _____State _____ Zip Code _____ Phone _____

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** ☐ female ☐ male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____