Health Form 2025 Quick Sticks Camp
For All Massachusetts Summer Day Camps

Camp Location: _____

Camper's Last Name: _____ First Name: _____ MI: _____

Home Address: _____
Street City State Zip

Birth Date: ____ / _____ /_____ Age: _____ Grade entering in upcoming fall: _____

Parent/Guardian Name: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

Emergency Contact Information – Required by the Board of Health

In the event that we are unable to reach you, please provide two alternate emergency contacts:

Emergency Contact Name 1: _____Phone: (_____) _____

Emergency Contact Name 2: _____Phone: (_____) _____

Camper Drop Off/Pick Up Information – Required by the Board of Health

Name of Person(s) for Drop Off: _____Phone: (_____) _____

Name of Person(s) for Pick Up: _____Phone: (_____) _____

Permission for Medical Care

I hereby authorize **Achieve Lacrosse Quick Sticks**, or any other appropriate members, to carry out the necessary procedures for diagnosis, immunization, medical treatment, and/or surgical treatment for my son/daughter _____ (Please print camper's full name). In rare instances, a medical or surgical emergency requiring treatment arises in which written consent by parents or guardians is legally required, but the proper person cannot be located. In this event, and in order to avoid delay that might jeopardize the life or recovery of a camper, we request the following permission from parents or guardians, with the understanding that every effort will be made to contact you in an emergency. I hereby grant permission to authorize any member of **Achieve Lacrosse Quick Sticks** or other physicians or surgeons, to give emergency anesthesia and perform medical or surgical procedures on my son/daughter named above in the event that he/she is unable to contact me when further delay might jeopardize life or impair recovery. I hereby grant permission to any hospital or physician service to submit and collect from my primary insurance company any and all appropriate charges incurred for services rendered at any of the above-mentioned facilities. I hereby grant permission for the release of any medical information necessary to process said claims for my child.

Insurance Provider Name: _____ Address: _____

Policy or Group Number: _____ Phone: (_____) _____

Parent/Guardian Signature: _____Date: _____ / _____ /_____

Printed Name: _____Relationship:_____

Health History

Camper's Name: _____

Allergies (include medications, foods, insect venoms): None _____ Yes, please list: _____

_____

_____

General Health History (include chronic illnesses, asthma, concussions, seizures, etc.): _____

_____

_____

Mental, Emotional and Social Health History (include ADHD, anxiety, depression, etc.): _____

_____

_____

Wears contacts? Yes ___ No ___ Sensitive to heat/cold? Yes ____ No ___

Asthma? Yes ___ No ___ Had Chicken Pox? Yes __ No ___

Hospitalized/Surgery in past year? Yes _____No _____ If Yes, please explain: _____

_____

Permission to use sunscreen? Yes _____ No ___

Currently taking medications? Yes _____ No ___ If Yes, please list: _____

_____

Bringing any medication to camp? Yes __ No ___ If Yes, it needs to be in original container and properly labeled. Please fill out the Medication Authorization for and return with Health Form.

Name of Medication(s)	Amount/Dose	How is it given?	When is it given?

By signing this form, we the undersigned swear that all the information is correct to the best of our knowledge.

_____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

Physician's Section – To be completed by Camper's Physician or Practitioner

This section must be completed by camper's physician/practitioner OR include a signed physical exam within the last 24 months of camp start date WITH a copy of immunization record. The date of the last tetanus immunization is required.

Date of last physical exam: _____ / _____ /_____ Height: _____ Weight: _____ M____ F____

Is the above camper physically fit for Achieve Lacrosse Quick Sticks? Yes _____No _____

Physician's Name (please print): _____Phone: (____) _____

Name of Practice: _____

Address: _____

Physician's or Practitioner's Signature: _____ Date:_____ / _____ /_____

Copy of Immunization Record Included _____ **Date of last tetanus booster:** _____ / _____ /_____