Return form to:

Summer Sports Clinics
UMass Lowell
One University Ave.
Lowell, MA 01854

(You may also bring this with you on the first day of the camp or clinic)

Participant Name: _____
(Last) (First) (MI)
Sport Clinic Attending: _____
Clinic Dates: _____

Medical and Immunization History
Camps and Clinics

Section I: (to be completed by Parent or Guardian)

Name: _____ Sex: M F Birth Date: ____/_____/_____

Address: _____ City: _____ State:____ Zip:_____

Father: _____ Telephone: _____ Alt. Phone:_____

Mother: _____ Telephone: _____ Alt. Phone: _____

Guardian is: ☐ Mother ☐ Father ☐ Other: _____
(Name, Address, Phone)

In case of illness or emergency the name and telephone number of a person to contact: (Relation to participant)

_____

Family Physician (Name and Address): _____
Family Physician Telephone Number: _____

Medical Insurance Company Name: _____ Policy Number:_____

In case of emergency, I hereby give permission to the Athletic Health Care staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child as named above.

Date: _____ Parent/Guardian Signature: _____

Section II: Physical Examination: (Must be in the preceding 12 months by a Medical Provider)

Child Name: _____ **Gender:** M F **Birth Date:** ___/_____/_____

Medical History: (please be sure to note significant disorders)

Allergies _____	Heart _____	Tuberculosis _____
Allergies _____	Kidney _____	Whooping Cough _____
Diabetes _____	Lung _____	Varicella _____
Neurological _____	Disabilities_____	Other _____

Pertinent Medical History:

_____

_____

_____

_____

Section III: Summary of Significant Treatment Program

Include Names/Doses of Medications to be used while at program. Medications MUST be In container with the original label.

_____

_____

_____

Section IV: Required Immunizations

MEASLES, MUMPS AND RUBELLA (MMR) VACCINE

First dose must be after age 12 months; 2 doses required

MMR #1 ____/____/____ (M) (D) (Year) MMR#2 ____/____/____ (M) (D) (Year)

POLIO VACCINE

____/____/____

A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio Vaccine (OPV) are required. If a mix of IVP/OVP was used, four does required.

Dates:

____/____/____
____/____/____
____/____/____

Completed primary series of polio immunizations? ☐ Yes ☐ No

Diphtheria and Tetanus Toxoids and Pertussis Vaccine

Minimum of our doses of DtaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all campers and staff who will be entering grades seven through 10. For campers and staff entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable).

Completed primary series of DTaP/DTP/DT? ☐ Yes ☐ No

Dates: ____/____/____ ____/____/____ ____/____/____ ____/____/____ Date of last Td ____/____/____

HEPATITIS B

Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____

Medical Exemption: the above named person does not have one or more of the required immunizations because he/she has a medical condition or religious objection. Documentation must be provided for either exemption.

Health Care Provider Signature and/or stamp: _____ Date: _____

Printed Names: _____

Address: _____ Telephone: _____