

**2020
CAMP APPLICATION
MEDICAL FORM**

**WESTERN NEW ENGLAND
SOCCER ACADEMY**

****This Medical form can be substituted by your child's Healthcare Provider Form**
If you do not have a medical form from your doctor, please fill out the information below**

SECTION III: Physical Examinations

(Must have been done by a medical provider within the preceding 24 months).

Medical History: (Please note significant disorders)

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

Pertinent Medical History: _____

Child Name: _____ Birth _____
Date: _____ Summary _____
of Significant Treatment Program including Names/dose of Medications
to be used while at program:

(Medications MUST be in a container with the original label)

Health Care Provider/Physician:

Signature and /or Stamp Required

Date: _____
Printed Name: _____
Address: _____
City: _____
State _____ Zip _____ Telephone: (____) _____

Person herein described has permission to engage in all prescribed camp activities
EXCEPT as noted here:

SECTION IV: Immunizations

Has completed primary series of tetanus/diphtheria? (four doses)

Yes _____ No _____

Primary Series - Type of Vaccine OVP IPV E-IPV ____/____/____

Laser Booster - Type of Vaccine OVP IPV E-IPV ____/____/____

Immunization	Dates
Diphtheria/tetanus (Td) Must be within last ten years	____/____/____
Measles #1 (Rubella, Red measles) Must be AFTER age 12 months or	____/____/____
MMR #1 or Positive Measles Titer (Blood Test)	____/____/____
Measles #2 (rubella, Red Measles) Must be at least 30 days AFTER first dose or	____/____/____
MMR#2	____/____/____
Mumps or MM#1 Must be AFTER age 12 months or Positive Mumps Titer (Blood Test)	____/____/____
Rubella (German Measles) or MMR #1 Must be AFTER age 12 months or Positive Rubella Titer (Blood Test)	____/____/____
Hepatitis B - those born AFTER 1-1-92 Dose #1 Dose #2 Dose #3	____/____/____ ____/____/____ ____/____/____

Medical Exemption: The above named person does not have one or more of the required immunizations because she/he has medical problem (s) that precludes the _____ vaccine (s).

<p style="text-align: center; font-weight: bold; margin: 0;">We Provide</p> <p style="margin: 0;">Experienced Coaches • Indoor and outdoor facilities • Superior Soccer Fields • T-shirt for Every Camper* • Certified Athletic Trainer on Staff • Swimming Pool with Life Guards on duty • Lunch • The most Instructional time of any area day camp! •</p>	<p style="text-align: center; font-weight: bold; margin: 0;">You Supply</p> <p style="margin: 0;">An attitude to Learn! • Cleats or Sneakers • Shin Pads • Soccer Ball • Swim Gear and Towel • Indoor Shoes in Case of Rain.</p>
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Please Print and Complete MEDICAL FORM
Mail With Check Made Payable To: Western New England Soccer Academy
114 Evergreen Drive East Longmeadow, MA. 01028