

**Tornadoes Soccer Academy**  
PO Box 6292, Talladega, AL 35161  
Phone # - (518) 209-4263  
Email: degasoccer@gmail.com

## DAY CAMP HEALTH HISTORY FORM

Part 1: Camper Information: To be completed by parent/guardian.

Camp Attending: \_\_\_\_\_  
Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Gender (circle one): M F  
\_\_\_\_\_  
\_\_\_\_\_  
Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Evening Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Cell Phone/Pager: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_  
Email: \_\_\_\_\_ Email: \_\_\_\_\_

Part 2: Emergency Contact Information:

Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Part 3: Insurance Information: Campers should be covered by their family's medical insurance policy. Tornadoes Soccer Academy (TSA) does not provide medical insurance of any kind. Local providers may require that you pay them directly at the time of service and then file for reimbursement with your insurance company. If you do not have insurance, write "none".

Medical insurance provider: \_\_\_\_\_  
Policy #/Group #: \_\_\_\_\_  
Address of insurance Provider: \_\_\_\_\_  
\_\_\_\_\_  
Name of policy holder: \_\_\_\_\_  
ID number: \_\_\_\_\_ Prescription Card #: \_\_\_\_\_  
Employer of policy holder: \_\_\_\_\_

Part 4: Dietary Restrictions: Please note any special dietary needs or food allergies:

\_\_\_\_\_

Part 5: Special Accommodations: Please list any special accommodations that are needed by your child for issues such as physical disability, vision impairment, hearing impairment, etc.

\_\_\_\_\_

\_\_\_\_\_

**SUMMER CAMP HEALTH HISTORY FORM**

Name: \_\_\_\_\_

**Part 6: Medical History:** Please check all that apply to your child and give necessary details below.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Migraines/headaches       | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> ADD or ADHD               |
| <input type="checkbox"/> Hearing/vision impairment | <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> Depression/anxiety        |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Urinary tract infections   | <input type="checkbox"/> Eating disorder           |
| <input type="checkbox"/> Bronchitis/pneumonia      | <input type="checkbox"/> Enuresis                   | <input type="checkbox"/> Learning disability       |
| <input type="checkbox"/> Ear/sinus infections      | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Eczema/skin disorder      |
| <input type="checkbox"/> Heart defect/disease      | <input type="checkbox"/> Neurological disorder      | <input type="checkbox"/> Hemophilia/blood disorder |
| <input type="checkbox"/> Seizures/fainting         | <input type="checkbox"/> Other, explain: _____      |  |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to medications, insect bites, etc.: \_\_\_\_\_

Does your child carry an epi-pen for allergies? \_\_\_\_\_

Operations or serious illnesses: \_\_\_\_\_

Under the care of a psychologist, psychiatrist, or counselor? \_\_\_\_\_

**Part 7: Medications Information:** Any medication brought to camp must be accompanied by a **written order from the camper's primary care provider** (Form included). Medication includes: medicines prescribed by a health care provider; all over-the-counter medications such as Advil, Tylenol, allergy meds; vitamins; and herbal supplements. Medication must also be sent in their original containers and labeled with the camper's name. All medications (including over-the-counter medications) must be given to the camp health director upon arrival to camp and will be kept locked in the camp health office. Campers may not keep medications with him or her (with the exception of inhalers, epi-pens, and insulin).

Please check one:

[ ] My child will be bringing medications to camp. Please list medications: \_\_\_\_\_

[ ] My child will not be bringing medications of any kind to camp.

**Part 8: Immunization Record:** Please attach a copy of your child's immunization record. It should provide proof of immunization against all of the following: diphtheria, haemophilus influenza type B (hib), hepatitis B, measles, mumps, rubella, poliomyelitis, tetanus, and varicella (chicken pox), and meningococcal vaccine. **Your child will not be able to participate in the camp and will be sent home if the immunization record is not attached per the ADPH.**

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## SUMMER CAMP CONSENT FORM

Name: \_\_\_\_\_

*Part 9: Consent for Medical Treatment:* This is to authorize the medical personnel of the camp, and/or off-campus medical facilities to provide necessary medical care to your child. It must be signed by a parent or legal guardian. . **Your child will not be able to participate in the camp and will be sent home if the consent for medical treatment is not signed per the ADPH.**

In the event of an emergency, I consent for medical personnel of Tornadoes Soccer Academy or the camp site or physicians of the nearest or most appropriate hospital to perform any necessary emergency treatment, including surgery, injection, or other procedures requiring the use of a local or general anesthetic. This authorization shall be in effect while my child is a student at the camp. I understand that I am fully responsible for all medical costs incurred by my child.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

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**SUMMER CAMP MEDICATION ORDER AND PERMISSION FORM**

Name of Camper: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Directions: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Is the camper self-directed? Y N

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Address of Physician: \_\_\_\_\_

Phone number of Physician: \_\_\_\_\_

I hereby give my permission for my son/daughter, \_\_\_\_\_,  
who is attending \_\_\_\_\_ at Tornadoes Soccer Academy, to  
take the above medication as ordered.

Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_

No medication (prescription or over-the-counter) will be given at camp until the camp health director receives this completed form or equivalent with the medication in its original container. All prescription medication must be appropriately labeled by the pharmacy and all over-the-counter medication must be in its original, unopened container. All medicine will be kept with the camp health director or designee.