PLEASE RETURN BY FAX 877-282-9440 OR SCAN TO EMAIL (amanda@bluechiplax.com)

PLEASE DO NOT MAIL - This form is for the 225 National Showcase ONLY!!

BLUE CHIP LACROSSE HEALTH EXAM/RECORD

Parent Email:____

(Confirmation of receipt will be sent to this address- PLEASE PRINT CLEARLY!)

Please CIRCLE the session your 225 National Showcase athlete is attending:

225 Rising Senior **225 Rising Junior** **225 Rising Sophomore** **225 Rising Freshmen**

Camper Name____ **Date of Birth**__________________**Phone #**___________________________

Address____

Emergency Contact Name____**Phone #**____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Date of exam_____/_____/_____

Individual CAN participate in all camp activities: YES NO If No please indicate exclusions_____________________________________

Medical care pertinent to routine care and emergencies:____

____

Is the individual taking prescription or over the counter medication(s)? If yes indicate names of medication(s):_____________________________

____

Will this medication be BROUGHT TO and TAKEN at camp? YES NO

Does the individual have allergies? YES NO
Explain:____

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

Does the individual have special needs? YES NO
Explain:____

This camper is up to date on all routine childhood immunizations YES / NO currently recommended by the American Academy of Pediatrics.

DATE OF LAST TETANUS SHOT__________________ **(a copy of the full immunization record is NOT REQUIRED)**

Print Name of Medical Care Provider____Phone#________________________________

Medical Provider's address____City________________________State_______Zip__________

SIGNATURE OF PHYSICIAN, PA, APRN or RN____Date________________________

(FORMS CANNOT BE ACCEPTED WITHOUT A PHYSICIAN'S SIGNATURE)