FAIRFIELD FIELD HOCKEY CAMP

Please use this form or your own physicians form.
Mail to: Cathy Hamill, 20 Rita Avenue, Fairfield, CT 06824

CAMP PHYSICAL EXAMINATION

NAME: _____ **Birthdate:** _____

ADDRESS: _____ **Gender:** _____

_____ **Age:** _____

Parents: _____

PAST HISTORY:

Chicken Pox: _____

IMMUNIZATIONS:

DTP Series Completed _____ **Last DT Booster** _____
Polio Series Completed _____ **Hep B** _____
Measles _____ **HIB** _____
Mumps _____ **Varicella** _____
Rubella _____ **MMR** _____

PHYSICAL EXAM NORMAL EXCEPT THE FOLLOWING:

_____ **Height** _____
Weight _____
_____ **B/P** _____
HCT _____
URINALYSIS _____
TINE _____

CAMP RESTRICTIONS:

Dietary: _____

Physical: _____

MEDICAL TREATMENT IN PROGRESS: _____

ALLERGIES: _____

Last Exam Date: _____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____