

Neil Cunningham's Soccer Camp Physician's Medical Statement

Camper's First Name: _____ Last Name: _____

Date of Birth: _____

Does this camper currently have or has she ever had any of the following? Please provide additional explanatory information for any yes response. Attach additional documentation if necessary:

| | | | |
|------------------------|-------|-------|-------|
| Hear Murmurs | _____ | _____ | _____ |
| Irregular Pulse | _____ | _____ | _____ |
| Dizziness/Fainting | _____ | _____ | _____ |
| Nose Bleeds | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ |
| Epilepsy | _____ | _____ | _____ |
| Neurological Disorders | _____ | _____ | _____ |
| Headaches | _____ | _____ | _____ |
| Asthma | _____ | _____ | _____ |
| Inhalers | _____ | _____ | _____ |
| Heat Exhaustion | _____ | _____ | _____ |
| Heat Stroke | _____ | _____ | _____ |
| Heat Cramps | _____ | _____ | _____ |
| Fractures | _____ | _____ | _____ |
| Sprains | _____ | _____ | _____ |
| Muscle Injuries | _____ | _____ | _____ |
| Allergies | _____ | _____ | _____ |

Please list all prescription and non-prescription medications the camper is currently taking:

Has the camper ever sustained a head or spinal injury? Has she ever lost consciousness? If yes, to either question, please explain the nature and cause of the injury.

Does the camper have any other medical problems that could interfere with full participation in physical activities? If yes, please explain:

VACCINATIONS: (Please indicate dates of administration below)

Tetanus_____ Measles_____ Mumps_____

I certify that I have reviewed the medical history and status of the above-names-person, and I certify that she has no medical problems that restrict her from participation in vigorous physical activity while attending Neil Cunningham's Soccer Camp?

Signature of Physician _____ Date _____

Print Physicians Name _____ Office Phone Number _____

Questions? Please contact Neil Cunningham at 540-458-8056 or CunninghamN@wlu.edu