FOUR STAR MEDICAL FORM

Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Address Line 2: _____ **Home Telephone:** _____
Area code - Telephone number

Fathers Name: _____ **Work Tele:** _____ **Cell:** _____

Mothers Name: _____ **Work Tele:** _____ **Cell:** _____

All campers must have their own medical coverage. The camp provides only excess coverage after your insurance policy has been utilized. Campers will not be allowed to participate unless this form is completed and signed by a parent /guardian and a doctor.

Campers Insurance Company: _____ **Policy Number:** _____

PHYSICAL EXAMINATION *(must be in preceding 12 months and done by a medical provider)*

Medical History: *(please note significant disorders)*

Allergies _____ **Heart** _____ **Tuberculosis** _____ **Kidney** _____

Lung _____ **Disabilities** _____ **Varicella** _____ **Diabetes** _____

Neurological _____ **Pertinent Medical History:** _____ **Birth Date:** ___/____/____

Summary of significant treatment program including names/dose of medications to be used while at camp.
*(Medications **MUST** be in a container with the original label).* _____

_____

IMMUNIZATIONS

Has completed primary series of tetanus/diphtheria? (Four Doses)	Yes ___ No _____
Completed primary series of polio immunizations?	Yes ___ No _____
Primary Series-Type of Vaccine OPV IPV E-IPV	____/____/____
Last Booster-Type of Vaccine OPV IPV E-IPV	____/____/____

IMMUNIZATION	**DATES**
DIPHTHERIA/TETANUS (TD) *must be within the last 10 years*	_____/_____/_____/_____/_____
Measles #1(Rubella, Red Measles)	_____/_____/_____/_____/_____
MMR#1	_____/_____/_____/_____/_____
or positive Measles titer (Blood Test)	_____/_____/_____/_____/_____
Measles #2 *must be at least 30 days After the first dose*	_____/_____/_____/_____/_____
or MMR#2	_____/_____/_____/_____/_____
Mumps or MM#1 *must be after age 12 months*	_____/_____/_____/_____/_____
or Positive Rubella 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 he has medical problem(s) that preclude the _____Vaccine(s)

Health Care Provider/Physician:

Signature and/or stamp _____ **Date:** _____

Printed Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Telephone: _____ **Parent Signature:** _____
Area code - Telephone number

Mail this form and payment (if by check) to:
Four Star Lacrosse
3 Sherwood Lane
Setauket, NY 11733
Questions? Call 631-689-0223