



Health Exam/Record, Insurance, & Authorization
Physical exams are valid for 3 years from date of last examination.

Last Name, First Name

Date of Birth

Phone Number

Parent/Guardian Address Phone

Emergency Contact Phone Cell Phone

Date of arrival at camp, Departure date

Insurance Information: Please provide family medical/hospital insurance information
Carrier or plan name: _____ Group#: _____

Authorization – This section must be completed by a parent/guardian of participants under 18 years old:

I, the undersigned, hereby give permission to Rabil Lacrosse, Inc. and its designee to provide and/or seek out required health care for the individual named above in the event such care is necessary. Second, I hereby give _____ (Facility Location) and its designee the authority to arrange for transportation as essential in providing appropriate medical care. Third, I hereby authorize Rabil Lacrosse, Inc. and its designee to release related records to the health care provider. Fourth, in the event I cannot be reached, I hereby authorize the physician chosen by Rabil Lacrosse, Inc. and its designee to administer treatment for the individual named above. I also understand that this form will be photocopied for accompaniment on any off-site trips. I verify that the dangers of the activities and the significance of this Release and Waiver were explained to the Participant and that the Participant understood them.

Parent signature: _____ Date: _____

THE FOLLOWING MUST BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

_____ Individual may participate in all activities

_____ Individual may participate except for:

Medical information pertinent to routine care and procedures:

Is individual taking prescription or over-the-counter medications(s)? YES NO

If yes, indicate names of medication(s):

Does the individual have allergies? YES NO If yes, explain: _____

Is the individual on a special diet? YES NO If yes, explain: _____

Does the individual have special needs? YES NO If yes, explain: _____

This individual is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatric and National Advisory Committee on Immunization Practices:
YES NO

Measles Hepatitis B: YES NO
Mumps Diphtheria: YES NO
Rubella Pertussis: YES NO
Chickenpox Polio: YES NO
Tetanus: YES NO

Comments: _____

Print name of medical care provider: _____
Medical Care Provider's address: _____ City: _____ ST: _____
Zip: _____

Signature of Physician, APRN or PA **Date form signed** **Phone number**

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