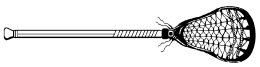

NEW ENGLAND TOP 150 LACROSSE CAMP Inc. PHYSICAL EXAMINATION
(MUST BE IN THE PRECEDING 18 MONTHS AND DONE BY A MEDICAL PROVIDER)

Campers Name _____

Medical history (Please note significant disorders)

Allergies _____ Heart_____ Tuberculosis_____
_____Kidney _____Whooping Cough_____
Diabetes_____Lung _____ Varicella _____
Disabilities_____ _Neurological _____ Other_____

Pertinent Medical History:_____

Summary of Significant Treatment Program, including Names/Dose of Medications to be used while at camp:
(Medications MUST be in an airtight container with the original label). _____
_____

NEED COPY OF IMMUNIZATIONS

Medical exemption: The above named person does not have one or more of the required immunizations because he/she has medical problems that precludes the _____ vaccine(s).

Health Care Provider Signature and/or Stamp: _____ **Date** _____

Printed Name_____

Address: _____ **Tel.** _____

COPY OF LAST PHYSICAL (Within the last 18 months)_____

Please mail or scan to E-mail : **For Information email Linda Brown: linda@netop150lax.com**

NEW ENGLAND TOP 150 Lacrosse Camp Inc.
PO Box 87
Portsmouth, RI 02871