

GOLDEN GOAL™ HEALTH HISTORY AND EXAMINATION
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We are delighted to welcome your children to **GOLDEN GOAL** and wish to provide you with information that will insure that your child is allowed to participate at **GOLDEN GOAL** and will be well cared for while away from home. **GOLDEN GOAL** will assure that adequate medical and nursing supervision and care, either at the Golden Goal, or readily available, is provided. The New York State Department of Health has issued Permit Number 57-BD32 to **GOLDEN GOAL**. It is imperative that you complete the necessary forms for your child to enroll at **GOLDEN GOAL**.

YOUR COACH/MANAGER/CHAPERONE MUST PRESENT ALL MEDICAL INFORMATION TO GOLDEN GOAL TO PRESENT DURING TEAM REGISTRATION IN ORDER TO PARTICIPATE AT GOLDEN GOAL!

1. Each participant under the age of 18 must have a physical within a year of the date of play, performed by a licensed health care provider. **GOLDEN GOAL** will supply you with the form. This form is to be filled out by the parents or guardian, and the release on the bottom of the form must be signed. This must be done even if the parents are in town or are coaches/chaperones. This form must also be completed and signed by the health care provider. Under New York law, **IT IS MANDATORY** that the immunization section of the form be complete with the dates of the immunization. It is **NOT** sufficient to state that all immunizations are up to date. The Coaches/chaperones of the team do not want to spend their first day at **GOLDEN GOAL** calling and faxing forms for you to complete so that your child qualifies to participate at **GOLDEN GOAL**.
2. All medications that are required by any participant while at Golden Goal must be kept by the Coach dispensed as directed by Coach. Please send the original prescription bottle, not envelopes of medication. All medications will be returned to the coach/chaperone at the conclusion of the Golden Goal program. It is required that over-the-counter drugs must also be kept in the Medical Building and dispensed only with parental direction. Please place these drugs (i.e. Advil, Tylenol, etc.) in the original container, in a baggie (with name on baggie or with a piece of paper inside the baggie with the participant's name and any pertinent instructions).
3. If you wish the Coach to be able to administer Tylenol or Ibuprofen to your child on any as needed basis, (for headache, muscle strain, or other minor problems), you must either send such medication with instructions (as noted above) or complete the section of the Golden Goal Health History and Examination Form giving permission for the Coach to administer Tylenol or Ibuprofen.

GOLDEN GOAL does not have a doctor on site. **GOLDEN GOAL** is approximately 12 miles from Glens Falls Hospital, which is a nationally recognized regional health care center. Any team member or guest of **GOLDEN GOAL** who requires care will be referred to the Glens Falls Hospital
<http://www.glensfallshospital.org>

We look forward to seeing you and your child at **GOLDEN GOAL**.

GOLDEN GOAL™ HEALTH HISTORY AND EXAMINATION (pg. 2 of 2)
To be completed by parent or guardian:

CHILD:

Sex: M or F DOB _____ Team Name: _____
Last Name _____ First Name _____ MI ____
Address _____

PARENT/GUARDIAN:

Last Name _____ First Name _____ MI ____
Home Phone _____ Work Phone _____
Address _____

SECOND PARENT/GUARDIAN OR CONTACT:

Last Name _____ First Name _____ MI ____
Home Phone _____ Work Phone _____
Address _____

If coming to Lake George area, where are parent(s)/guardian staying:
_____ Phone # _____

Health History: (complete if applicable and give approximate dates or other pertinent information)

Allergies: _____

Operations or serious injuries (please include dates):

Disabilities or chronic/reoccurring illness:

Any specific activities to be encouraged or limited by physician's advice: -

Dietary modifications: _____

Current medication (please send with instructions):

Name of family physician: _____ Phone # _____

Do you carry family medical/hospital insurance? _____

Carrier: _____ Policy/Group # _____

Suggestions or health related information for Golden Goal personnel: _____

My child has my permission to give to be given Tylenol or Ibuprofen on an as needed basis.
TYLENOL _____ IBUPROFEN _____ Dosage _____ Comments: _____
Please state your choice of medication, dosage and special instructions. If you do not want your child to receive Tylenol or ibuprofen, please write NO next to both over the counter medications above.

IMPORTANT - THIS CONSENT MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed Golden Goal activities except as noted. I hereby give permission to the Coach and the staff at the Golden Goal to secure appropriate medical care, which may include x-rays, routine tests and treatment for my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by Golden Goal to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of the Golden Goal.

Signature of parent/guardian _____ **Date** _____

Please check all that apply to the participant:

- ____ ADD/ADHD ____ Frequent Ear Infections ____ Asthma ____ German measles ____ Chicken Pox
____ Bleeding/Clotting Disorder ____ Heart Defect/Disease ____ Hypertension ____ Convulsions/Seizures ____ Measles
____ Diabetes ____ Mononucleosis ____ Hay Fever Ivy Poisoning, etc. ____ Insect/Bee Stings Penicillin ____

Other (please list):