CONFIDENTIAL

2017 Ultimate Spin Basketball Camp
Medical Information Form

Camper's Last Name_____ First Name_____

D.O.B._____ Gender_____

Address_____

Home Phone_____ Work Phone_____

Primary Contact Name_____ Cell Phone# _____

Address_____

Other Contact info (email, pager, etc.)_____

Alternate Emergency Contact_____ Home Phone#_____

Other Contact info (cell phone, etc.)_____ Work Phone#_____

Health History (Please Check any of the below that apply)

Recurrent chronic illness_____ Illness Lasting more than 1 week_____ Hospitalization_____
Surgery_____ _____Allergy to Medication Missing Organs_____
Allergic to Bees? Y N If so does your child use EpiPen? Y N

Allergies to Foods? Y N If so, please list_____

Allergies to Other substances? Y N If so, please list_____

Chest Pain with exercise?_____ Asthma?_____ Uses Inhaler?_____

Dizziness, fainting, frequent headaches, migraines, convulsions?_____ Concussion or unconsciousness_____

Heat convulsions, heat stroke, or other problems in heat?_____ Glasses or Contacts_____

Is there a history of broken bones or joint or muscle injury?_____ Taking any medications?_____

Dizziness or fainting during exercise?_____ Heart or blood pressure problems?_____

Wears dental bridges, braces, or retainers?_____ Hearing Loss?_____

History of autism CP or other developmental differences_____ Any eating or nutritional disorders?_____

History of bulimia, anorexia, depression, severe anxiety or other mental or emotional problems?_____

What is the date of the camper's last tetanus shot?_____

Primary Physician's Name_____ Phone #_____

Is your child currently under the care of a physician? Y N
If yes
Conditions for which he/she is receiving treatment_____

Are there any significant issues or events in your child's life about which we should know (divorce, death in the family, etc.)?_____

Please elaborate on any mental and physical health issues:

_____

_____

_____

I give permission for_____ (camper name)

1. To be administered first aid, topical and other medications.
2. To be rendered emergency hospital treatment including anesthesia. I understand that every reasonable effort will be made to contact me or my alternative emergency contact prior to hospital treatment.

_____ _____

Parent/ or Legal Guardian Date