

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