THE CHUCK MCBREEN BASKETBALL CAMP - MEDICAL INFORMATION FORM

Please print and fill out form. For health regulation this form MUST be filled out completely prior to the start of camp. **There are no substitutes to this form.**

Last Name: _____ First Name: _____ ❑ Boy ❑ Girl

Age as of Camp: _____ DOB: _____ / _____ / _____
Month Day Year

Street Address: _____

City / Town: _____ State: _____ Zip Code: _____

Home Phone:(_____) _____ – _____ Email *(Required)*: _____

Father's Work Phone: (_____) _____ – _____ Mother's Work Phone: (_____) _____ – _____

Father's Mobile Phone: (_____) _____ – _____ Mother's Mobile Phone: (_____) _____ – _____

If parent is not available in the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone:(_____) _____ – _____

Name: _____ Relationship: _____ Phone:(_____) _____ – _____

Personal Physician: _____ Phone:(_____) _____ – _____ Date of most recent exam: ____ / ____ / ____

Camper's health history information required prior to the start of camp. Camper's insurance policy is the primary coverage. ***(Required)***

Insurance Carrier: _____ Policy #: _____

Physician: _____ Phone:(_____) _____ – _____ Date of recent exam: ____ / ____ / ____

Parent/Guardian can fill out this form. Contact campers physician for Medical History. Please indicate whether or not the camper has history or symptoms of the following:

General Information	Yes	No	General Information	Yes	No	General Information	Yes	No
Serious Injury	❑	❑	Serious Illness	❑	❑	Mental Illness	❑	❑
Surgery	❑	❑	Rhuematic Fever	❑	❑	Behavioral	❑	❑
Deformity	❑	❑	Digestion	❑	❑	Attention Disorder	❑	❑
Nose, Sinus	❑	❑	Chest, Lung	❑	❑	Sleep Walking	❑	❑
Skin, Gland	❑	❑	High Blood Pressure	❑	❑	Hernia	❑	❑
Ears, Eyes	❑	❑	Heart Murmur	❑	❑	Back, Limb, Joint	❑	❑
Stomach, Bowels	❑	❑	Fainting	❑	❑	Teeth	❑	❑
Appendicitis	❑	❑	Convulsions	❑	❑	Dentures	❑	❑
Kidneys	❑	❑	Heart Trouble	❑	❑	Tonsils	❑	❑
Urine Infection	❑	❑	Cancer/Leukemia	❑	❑	Contact Lenses	❑	❑
Bed Wetting	❑	❑	Diabetes	❑	❑	Asthma	❑	❑
Menstrual	❑	❑	Hemophilia	❑	❑	Take Prescription Daily	❑	❑

CAMPER'S IMMUNIZATION HISTORY

The State of New Jersey requires that the camper's immunization history is on file prior to the camper's participation. The camper WILL NOT be allowed to participate until this information is on file. All dates must be completely filled in. The form WILL NOT be accepted without proper months and years indicated. Please do not submit photo copy of doctor's immunization's history.

Immunization	Month	Year
Tetanus Toxoid		
Measles		
Polio		
Diptheria		
Hepatitus B		
Pertussis		
Rubella		
Mumps		

THE CHUCK MCBREEN BASKETBALL CAMP-MEDICAL INFORMATION FORM

Please print and fill out form. For health regulation this form MUST be filled out completely prior to the start of camp.
There are no substitutes to this form.

Is Camper taking any medication? ❑No ❑Yes *If yes, please explain:*

All medication must be checked in the first day of camp. Medications must be in the original container and clearly marked with the camper's name and dosage. By signing this form parental permission is given to camp personal to administer such medications.

Has there been any surgery, injury, illness, allergy or change of health status since last examination? ❑No ❑Yes *If yes, please explain:*

Does Camper have any known allergies(food, medications, insect, plants..etc)? ❑No ❑Yes *If yes, please explain:*

Emergency Medical Authorization: The applicant is in good physical and mental health and has parental permission to participate in this program and to engage in all prescribed camp activities. There is a potential risk of injury in the participation of Camp activities. Parent/guardian hereby assumes all risks and hazards incidental to the applicant's participation in camp and does hereby waive, release, absolve and agree to hold harmless the camp, the Camp Directors and Camp Staff from any claim arising out of injury to applicant. In the event that parent/guardian cannot be reach in an EMERGENCY, parent/guardian hereby gives permission to the physician selected by the Camp to hospitalize, secure proper treatment for, and to order injection, anesthesia of surgery for applicant as needed.

Signature of Parent/Guardian: _____

Print name: _____

Date: _____