

**THE BASKETBALL FACTORY
YOUTH CAMP HEALTH EXAM/RECOR
FOR CAMPERS AND STAFF**
(Any physical you have had since September 2010 is acceptable.)

- Camper
 Staff

Name _____ Date of Birth _____ Phone _____

Guardian _____ Address _____

Emergency Contact _____ Telephone _____

Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

_____ May participate in all camp activities.

_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription medication? YES NO

If yes, indicate prescription: _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

| | Yes | No | | Yes | No |
|------------|-----|----|-------------|-----|----|
| Measles | | | Hepatitis B | | |
| Mumps | | | Diphtheria | | |
| Rubella | | | Pertussis | | |
| Chickenpox | | | Polio | | |
| Tetanus | | | | | |

Comments: _____

Print name of medical care provider: _____ Telephone _____

Medical Care provider's address: _____

Signature of Physician, APRN or PA

Date Form Signed

DATE OF EXAM

I the parent/guardian (circle one) hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusion, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me at to the effect of such examinations or treatment on my child's condition. I have read this form and I certify that I understand its contents. I hereby give my consent to **THE BASKETBALL FACTORY CAMP**, who will be caring for my child _____ for the period _____ to _____ to arrange for routine or emergency medical/surgical/dental care and treatment necessary to preserve the health of my child. I acknowledge that I am responsible for all reasonable charges in connection with treatment rendered during this period.

Signature of Parent or Guardian/Date _____

Please mail this form to: The Basketball Factory PO Box 904, Wallingford, CT 06492