

**Below The Rim Basketball Camp**  
**Health History and Examination Form**

**Please return to :**  
Below the Rim Basketball Camp  
16 Whispering Way  
Stow, Ma. 01775

**Please complete and return by:**  
May 1<sup>th</sup> 2020

This side to be filled in by a parent and checked with physician at the time of examination:

Camper \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

**Health History ( Yes/No: give dates if applicable)**

Frequent Ear Infections	Hay Fever	Chicken Pox
Heart Defect/Disease	Poison Ivy	Measles
Convulsions	Insect Stings	German Measles
Diabetes	Penicillin	Mumps
Bleeding/Clotting Disorders	Other Drugs	Asthma

Operations or serious injuries ( Dates ) \_\_\_\_\_

Chronic or recurring illness \_\_\_\_\_

Other diseases or details of above \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_  
( If other than examining physician)

Do you carry family medical/hospital insurance ? \_\_\_\_\_

If so indicate : Carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Any specific activities to be encouraged \_\_\_\_\_

Or restricted ? \_\_\_\_\_

Suggestions on health related information to be shared with appropriate staff members \_\_\_\_\_

Important - Must be completed for Attendance

Parents Authorization: This health history is correct as far as I know, and the person herein described has the permission to engage in all precibed camp activities, except as noted by me and the examining physician.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child named above. I also agree to give permission to photocopy this from for use of camp.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*This side to be filled out by licensed physician.*

## Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Month/Yr	Month/Yr	Month/Yr	Month/Yr	Month/Yr
DPaT Diphtheria, Pertussis, Tetanus					
TD (Tetanus, Diphtheria)					
Tetanus					
Polio					
MMR Measles, Mumps, Rubella					
Varicella					
Hepatitis B					
Hib (Haemophilus influenza)					
Other					

Date of last physical examination: \_\_\_\_\_  
 (Must be within 12 months of child's attendance at camp)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Is the applicant currently under the care of a physician? If yes, why.

\_\_\_\_\_  
 \_\_\_\_\_

### Recommendations and/or restrictions while in camp:

Allergies (food, drugs, insects) \_\_\_\_\_

\_\_\_\_\_

Current medications : \_\_\_\_\_

Is parent sending it to camp ? \_\_\_\_\_

(Prescription medication must be in original container with doctor's prescription on it and must be kept in director's office)

Special diet \_\_\_\_\_

Restrictions Swimming, diving \_\_\_\_\_

Strenuous activity \_\_\_\_\_

Other \_\_\_\_\_

I have examined the child herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in all camp activities, unless otherwise noted above.	
Licensed Physician's Signature _____	Date _____
Address _____	Phone _____

**Please sign both sides and return to:  
Below The Rim Basketball Camp Inc  
16 Whispering Way  
Stow, Ma 01775  
Tel. No (978) 562 5603**

In consideration of my son/daughter becoming a camper at the Below The Rim Basketball Camp Inc (the "camp"), I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_ (please print). Hereby authorize the camp or its representatives to obtain emergency medical treatment on behalf of my son/daughter in the event that, in the opinion of the said camp, my son/daughter is in need of such treatment. I further agree that I will be responsible for the payment of such medical treatment and further release said camp or its representatives for any damages sustained by me in the connection with the providing of emergency medical treatment. The camp agrees to contact the parents or guardian as soon as is reasonably possible after the event which requires said emergency treatment, at the telephone number(s) indicated on the back of this form.

I further agree that I will be responsible for the payment of any cost of medical treatment of any such nature which arise in connection with any sickness or accident which may occur during that period and my son/daughter is at the camp, whether such expense is incurred during or subsequent to the time that my son/daughter attends the Camp and will indemnify and hold harmless the Camp for any claims for payment by the providers of said medical care.

Signature of Parent or Guardian. \_\_\_\_\_

Date \_\_\_\_\_

**Please complete and sign the back of this form. Thank you**

## **Student Emergency Medical Release Information**

Please Print:

Student's Name \_\_\_\_\_

Student's Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Name of Nearest Relative to be notified if parents cannot be reached. \_\_\_\_\_

Address \_\_\_\_\_

Phone Number Home \_\_\_\_\_ Work \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_

List of Allergies \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Date of last Physical Examination \_\_\_\_\_

Date Student will be attending camp \_\_\_\_\_

Signature of Parent/ Guardian \_\_\_\_\_

Please check if you do not want photographs of your child on our website or future publications. \_\_\_\_\_

