HOOP BASKETBALL HEALTH FORM

SESSION: _____ DATE OF SESSION:_____

NAME: _____ DOB _____

ADDRESS: _____

IN CASE OF EMERGENCY NOTIFY:

NAME: _____PHONE NUMBERS_____

NAME: _____PHONE NUMBERS _____

HEALTH INSURANCE: _____GROUP_____ INS #_____

HEALTH STATUS

Health history: past or present:
[ ] Asthma [ ]Diabetes [ ] Epilepsy [ ] Heart disease/ high blood pressure
[ ] Allergies: Foods: _____ Medicines: _____
Plants: _____ Insect bites:_____
Describe reaction:_____
Date of last Tetanus shot:_____

Please Check:
_____ This camper is healthy and may engage in all usual camp activities.

_____ Any physical or behavioral conditions that may affect or limit full participation in basketball or swimming? Please describe: _____

Primary Care Provider's name: _____
Address _____Phone #: _____

PARENT'S AUTHORIZATION FOR CARE:
IF A MEDICAL EMERGENCY ARISES, I AUTHORIZE HOOP CAMP TO SELECT A PHYSICIAN/ HOSPITAL FOR EMERGENCY TREATMENT AS NECESSARY FOR MY CHILD.
SIGNATURE_____DATE:_____

Parental permission for over the counter medication:
The camp nurse has my permission to give my son/daughter OTC medicine for the treatment of a fever (100.0 degrees or higher), headaches, muscle strain, or hives/rash. You will be notified if the problem persists.

CHECK ONE OR MORE: Tylenol [ ] Ibuprofen [ ] Benadryl [ ]
SIGNATURE_____DATE:_____

HOOP BASKETBALL CAMP

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

ALL PRESCRIPTION MEDICATIONS MUST BE IN ORIGINAL CONTAINERS AND LABELED WITH CAMPER'S NAME, NAME OF DRUG, STRENGTH, DOSAGE, FREQUENCY, AND AUTHORIZED PRESCRIBER OR DENTIST'S NAME.

PRESCRIPTION MEDICATION
Drug name: _____
Condition treated: _____
Dosage: _____ Time of day medication is given: breakfast lunch dinner bedtime

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Drug name: _____
Condition treated: _____
Dosage: _____ Time of day medication is given: breakfast lunch dinner bedtime

Authorized prescriber for administration of above medication:
Prescriber's name _____ Phone #_____
Address_____

ALL OVER THE COUNTER MEDICATION MUST ALSO BE IN THE ORIGINAL CONTAINER WITH THE CAMPER'S NAME ON THE BOTTLE. A PARENT'S SIGNATURE IS REQUIRED.

Drug name_____
Condition to be treated (e.g., Headache, fever, body aches) :_____
Dosage to be given_____

Drug name_____
Condition to be treated (e.g., Headache, fever, body aches) :_____
Dosage to be given_____

Parental signature_____ Date_____

AUTHORIZATION /APPROVAL FOR SELF ADMINISTRATION OF EMERGENCY MEDICATION

During his/her time at camp the camper is permitted to carry and self- administer the following emergency medication / device.

Asthma inhaler Epi Pen Other_____

According to Maine State Law 2496 a written approval from a camper's primary care provider and his /her parents as well as a review by the camp nurse is necessary to allow a camper to carry and self administer the above emergency medications.

Primary Care Provider's authorization / approval for self administration: Signature_____ Date

Parent's authorization / approval for self administration: Signature_____ Date

Camp Nurse has reviewed camper's knowledge and ability to self administer the above medication following outlined procedures in the Hoop Camp policies. Signature_____ Date