

**HOOP BASKETBALL HEALTH FORM**

SESSION: \_\_\_\_\_ DATE OF SESSION: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

NAME: \_\_\_\_\_ PHONE NUMBERS \_\_\_\_\_

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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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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 \_\_\_\_\_

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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