2018 Michelle Campbell Basketball Camp
Health History Report

(To be completed by a parent or guardian)

This form will be retained with the Camp Athletic Trainer and will be available to program staff in case of an emergency.

Please Print

Participant's Name: _____ Sex: ___ Male ___ Female
Last First MI

Home Address: _____ Date of Birth: _____
Street

_____
City State Zip Code

Home Phone Number: ( ) _____-_____

Primary Guardian: ___ Mother ___ Father ___ Both

Mother's Name: _____
Last First MI

Address (if different):_____

Mother's Home Phone: ( ) _____-_____

Cellular: ( ) _____-_____ Work: ( ) _____-_____

Father's Name: _____
Last First MI

Address (if different): _____

Father's Home Phone: ( ) _____-_____

Cellular: ( ) _____-_____ Work: ( ) _____-_____

Emergency Notification: You must specify a person to be notified if the above parents are unavailable. We will attempt to contact parents first. This must be a person not listed above or residing at the same residence.

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

Phone: Home ( ) _____-_____ Work ( ) _____-_____ Cellular ( ) _____-_____

Health Care Provider Information

Primary Health Care Provider: _____ Phone Number: ( ) _____-_____

Address: _____
Street City State Zip Code

Participant's Name: _____
Last First MI

Personal History **Check Yes or No in each row**

	Yes	No	Comments, answer questions
Allergies, Food or Drug			
Anxiety (nervous problem)			
Asthma			Cause:
Bone, joint, muscle or other orthopedic problems			Describe:
Diabetes			
Eating Disorder			
Emotional or psychiatric problems			
Epilepsy or seizures			
Fractures (bone)			Where & Type:
Hay Fever			
Hemophilia (bleeding problem)			Type:
Other Blood Disorders			Type:
Hospitalization			When & Why:
Mental Illness			
Migraine Headaches			
Muscle weakness or paralysis			Cause / Date:
Otis Media (ear infections)			
Pneumonia			Dates:
Shingles (Zoster)			
Sight Impairment			Glasses or Contacts (circle one)
Stomach or intestinal problems			Type & Date:
Surgery			Date & Where:
Tendonitis			Date & Where:
Thyroid problem			Type:

Health Insurance (Please provide specific insurance information. This information is required by the hospital when treating patients.)

Insurance Co. Name: _____ ID Number: _____

Insurance Co. Address: _____ City/ State/ Zip: _____
Street/Box Number

Subscriber's Name: _____ Camper's relationship to subscriber:_____

Group Number: _____ Please attach a copy of family prescription / insurance card if applicable.

Participant's Name: _____
Last First MI

Parent / Guardian Waiver

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed program activities, except as noted by me. We do herby waive, release, and forever discharge said organization, its staff, officers, agents, representatives, employees, and their successors and assign from any and all claims for damages occurring during the participant's stay at camp, her participation in activities arising from traveling to or from camp, whether said accident, injury, or loss is due to negligence or not. I hereby give my permission for treatment of illness and injury at the **Michelle Campbell Basketball Camp** and for emergency medical treatment at the Hospital.

Date: _____ Signature: _____

HIPAA – Authorization to Disclose Information

I, the parent or guardian of the camper attending the **Michelle Campbell Basketball Camp**, authorize the use/disclosure of the camper's individual health information to the Hospital and any other facility which is needed in the event that the camper is hospitalized. I understand that authorizing the disclosure of this health information is voluntary. I can refuse this authorization. I need not sign this form in order to receive treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this information, I must do so in writing and present my written revocation to the **Michelle Campbell Basketball Camp** Athletic Trainer.

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Date: _____ Signature: _____

Medication

This information is required in the event of an emergency.

Sections A must be completed by the parent or guardian if the camper takes prescription and/ or non-prescription medications at home.

Allergies: _____

Date of Birth: _____ Weight: _____ Height: _____ Age: _____

Diagnosis	Name of medication	Route	Dosage	Frequency	Parent / Guardian's Signature

Participant's Name: _____
Last First MI

Section B must be completed by the camper's **health care provider** if they will take medication **during camp hours.**

Allergies: _____

Date of Birth: _____ Weight: _____ Height: _____ Age: _____

Diagnosis	Name of medication	Route	Dosage	Frequency	Health Care Provider's Sign	Parent / Guardian's Sign

Written authorization by a parent /guardian and the health care provider is necessary for a camper with a severe medical condition to carry an **EPI Pen / Rescue Inhaler**.

Condition	Medication	Health Care Provider's Signature	Parent /Guardian Signature
	EPI PEN: (Name)		
	Rescue Inhaler: (Name)		

I give permission for my child _____ to receive the medication(s) as prescribed above by our licensed health care prescriber. The medication listed in section B is to be provided by me in the **properly labeled original container from the pharmacy.** I understand that my child will be supervised by the **Michelle Campbell Basketball Camp Athletic Trainer** in taking her own medications.

Parents will be notified and campers will be sent home if they carry medication without proper authorization from a licensed health care provider and parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Return this form to:

Michelle Campbell Basketball Camp
P.O. Box 9467
Trenton, NJ 08650

Fax: 609-208-3428