RICH FALK BASKETBALL CAMP
MEDICAL HISTORY AND TREATMENT FORM

Parents-please print and complete this form prior to check-in. Parents will give this form to our athletic trainers at check-in and have time to discuss any medical concerns. Please print clearly.

SECTION A

Name of camper _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (ZIP)

Birthdate ____/____/_____ Age ___
mo day yr

Parent or guardian's name _____

Address (if different than camper's) _____
(Street) (City) (State) (Zip)

Occupation _____ Employer _____

Employer's address _____
(Street) (City) (State) (Zip)

Parent/guardian's phone numbers _____ _____
(Home) (Cell)

SECTION B (Insurance Information) Camper must be covered by health insurance.

Name of insurance company _____

Address of company _____
(Street) (City) (State) (Zip)

Health insurance policy number _____

SECTION C (Medical Treatment Authorization & Liability Release)

I, the undersigned parent or guardian, do hereby grant my permission for my child to attend the Rich Falk Basketball Camp and fully participate in all activities thereof. In order that my child receive the necessary medical treatment in the event of an injury or illness, I hereby authorize the Rich Falk Basketball Camp to obtain medical treatment for my child for such an injury or illness during camp and I hereby release and agree to hold harmless Falk Family Basketball Camps, LLC, the Rich Falk Basketball Camp, its agents, employees, affiliates, and representatives from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for medical care and treatment will be forwarded to me or my insurance company and that it will by my responsibility to see that such bills are paid.

I further acknowledge, understand, and agree that by participating in this camp, there is a possibility of physical injury or illness and that my child is assuming the risk of such injury or illness by his participation.

_____ _____ _____
(Parent/Guardian's Signature) (Parent/Guardian's Printed Name) (Date)

SECTION D (Medical History Information) – To be completed by parent **or** physician

Height_____ Weight_____ Age_____ Date of last tetanus injection_____

Please circle diseases camper has had:

Mumps Measles Polio Whooping Cough Chicken Pox

Does the camper have any allergies to any medications?

If so, please list:

_____

Is the camper now under the care of a physician or taking any medication? If so, please explain:

_____

Does the camper have any of the following frequently or is he a victim of any of the following:

_____nosebleeds	_____rupture	_____ear aches
_____stomach cramps	_____epilepsy	_____heart condition
_____sore throats	_____diabetes	_____heat exhaustion

Please list and describe any injuries or illnesses the camper has endured **in the last six months**:

_____

Does the camper have a history of any of the following? If yes, please explain:

_____head injury_____
_____fractures_____
_____sprains_____
_____strains_____
_____surgery_____

Has the camper ever been hospitalized? If yes, please explain:_____

_____

Please attach any pertinent information a physician may need in case of treatment or emergency.

_____ _____
(Camper's physician's name) (Physician's address)

_____ _____
(Physician's phone number) (Parent/Guardian signature)

NOTE: ANY ILLNESS, INJURY, MEDICAL PROBLEM OR PHYSICAL DISABILITY OF A POTENTIALLY SERIOUS NATURE MUST RECEIVE THE CAMP DIRECTOR'S APPROVAL BEFORE CAMP PARTICIPATION WILL BE GRANTED. PLEASE CALL GEOFF FALK AT (630) 673-1552 WELL IN ADVANCE OF CAMP IN SUCH A SITUATION.