LAST NAME _____ FIRST NAME _____

MEDICAL INFORMATION FORM

FULL NAME _____ D.O.B. _____

ADDRESS _____ Male Female

CITY _____ STATE _____ ZIP _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

IMMUNIZATIONS: *(Dates for each dose)*	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Hep B					
DTP/DT/DT&P					
Td					
OPV/IPV					
MMR					
Varicella					
Haemophilus Influenza type b	(date)				

Chicken Pox: Age _____ *(Please check)*

Weight _____ Height _____ BP _____

Yes No (Please Check if Applicable)

Asthma: Mild Moderate Severe Exercise Inducer

Allergies: Medication Food Seasonal Other _____

AnaphylacticReaction: Insect Food Latex

EPIPenn/EPIPenJr.: If yes, please include a doctor's order stating emergency use of pen.

Diabetes: Type I Type II

SeizureDisorder

(Please Check)

Restrictions: The following restrictions apply to this individual –

Dietary

Does not eat red meat Does not eat pork Does not eat eggs Does not eat dairy products

Other *(describe)* _____

GeneralHealthHistory that applies to this individual

	Yes	No		Yes	No
Any recent injury, illness or infectious disease?			Ever been diagnosed with a heart murmur?		
Have a chronic or recurring illness?			Ever had back problems?		
Ever been hospitalized?			Ever had problem with joints? (i.e. knee, ankle)		
Ever had surgery?			Have an orthopedic appliance for camp?		
Have frequent headaches?			Have any skin problems? (i.e. acne, rash)		
Ever have a head injury:			Had mononucleosis in the past 12 months?		
Ever been knocked unconscious?			Had problems with diarrhea/constipation?		
Wear glasses, contacts?			Have problems with sleepwalking?		
Ever had frequent ear infections?			Have a history of bed-wetting?		
Ever passed out during or after exercise?			Ever had an eating disorder?		
Ever been dizzy during or after exercise?			Ever had emotional difficulties for which professional help was sought?		
Ever had seizures?					
Ever had chest pains during or after exercise?					
Ever had high blood pressure?					

Please explain "Yes" answer on questionnaire

INJURY OR ILLNESS JOURNAL

a. Description of injury/illness: _____

b. Description of how incident occurred if applicable: _____ c. Date: _____

d. Date parents were initially called: _____ e. Date parents were called on follow-up: _____

LAST NAME FIRST NAME

Explanation of "YES" answers from previous page. _____

_____

_____

_____

I have examined this patient and in addition, the health history and immunization records have been reviewed. There are no apparent contraindications to participating in intense wrestling camp activities.

Date of Last Physical: _____ Physician's Name: _____

Physician's Address: _____

Physician's Telephone #: _____

Today's Exam Date: _____

_____
Physician's Signature

The Parent/Guardian by his/her signature denies that any significant health problems have occurred ***since the above date.***

Today's Date: _____

_____
Parent/Guardian Signature

CONSENTTOTREAT

I grant to medical personnel of Pop's Athletics, LLC permission to provide medical care for conditions which arise during participation in Pop's Athletics, LLC wrestling. Every effort will be made to contact parents for specific permission if general anesthetic is indicated. I hereby authorize the administration of whatever medical or surgical treatment may, in the judgment of the physician, be necessary and advisable for my child. Pop's Athletics, LLC is not responsible for participants who arrive sick or injured. (See Policy Letter)

_____
(Child's Name)

_____ _____
Parent/Guardian Signature (Date)

*****Isthereanythingelseyouthinkmightbehelpfultousincaringforthisplayer?Ifyes,pleaseattachanexplanatoryletter.**
PLEASENOTIFYUSIFANYMEDICALTREATMENTORPROGRAMWILLCONTINUEDURINGTHISSTAY.

Required
MUST BE FILLED OUT

EMERGENCYINFORMATION: (If parents cannot be reached)

NAME _____ RELATIONSHIP _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE # _____ EMAIL ADDRESS _____

Required
MUST BE FILLED OUT

INSURANCEINFORMATION:

Policy Holder _____ Policy Holder D.O.B. _____

Policy Holder Social Security # L_____–L_____–_____

Company Policy is held with _____

PO Box # and address of Insurance Company _____

800 # of Insurance Company _____

Additional Information _____

LAST NAME FIRST NAME

Prescription and Non-Prescription Medication

Permission Form

(To be completed by Parent/Guardian)

NAME OF PLAYER _____

NAME OF PARENT/GUARDIAN _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

EMERGENCY# _____ NAME _____

FOOD/DRUG ALLERGIES _____

Please list ALL medications (including over-the-counter or non-prescription drug) taken routinely. Bring enough medication to last the entire time at camp. Keep original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration

Yes No

Non-Prescription Medication

Allowed to take "over-the-counter" medications during camp stay (Advil, Tylenol, Tums, etc.).

Yes No

Prescription Medication

Prescription medications will be taken during camp stay. Please list each drug separately in the boxes below (This includes inhalers/epi pens).

Name of Medication _____

Dose given at camp _____ (i.e. 1x/day, 2x/day) Duration of Order _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements _____

Name of Medication _____

Dose given at camp _____ (i.e. 1x/day, 2x/day) Duration of Order _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements _____

Name of Medication _____

Dose given at camp _____ (i.e. 1x/day, 2x/day) Duration of Order _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements _____

Parent/Guardian Signature

Physician's Signature