Medical Review: _____

MARIST COLLEGE SPORT CAMP/CLINIC HEALTH FORM
PERSONAL INFORMATION & MEDICAL HISTORY

Name _____ Birth Date _____ Age at Clinic_____ Gender: ☐ Male ☐ Female
Last First MI

Home Address _____
Street address City State Zip

Parent/guardian _____ Home Ph. _____ Cell Ph. _____

Home Address _____ Work Ph. _____
(if different from above) Street address City State Zip

2nd Parent/guardian _____ Home Ph. _____ Cell Ph. _____

Emergency contact (other than parent or guardian):

1. Name _____ Home Ph. _____ Cell Ph. _____

Address _____ Work Ph. _____
Street address City State Zip

2. Name _____ Home Ph. _____ Cell Ph. _____

Address _____ Work Ph. _____
Street address City State Zip

AUTHORIZATION TO RELEASE CHILD

I understand that in addition to the names listed above for emergency, these individuals are also authorized to pick up the participant. I must also include one local name and phone number for emergency purpose, other than immediate family members. Under no circumstance will my child/children be released to individuals other than those listed above without my written authorization.

HEALTH HISTORY

The following information must be completed by the parent/guardian of the participant. The intent of this information is to provide health care personnel the background to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided, in writing, to the Health Director, or designee, upon participant's arrival at the sports camp/clinic. Please provide complete, accurate information to ensure the health care personnel are aware of your child's needs.

GENERAL QUESTIONS: Please explain all "**Yes**" answers below.)

Has/does the participant:	**Yes**	**No**
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections or loss of hearing?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur/disease?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have any skin problems (e.g., itching rash, acne)?	☐	☐
19. Have diabetes?	☐	☐
20. Have asthma?	☐	☐
21. Use an inhaler?	☐	☐
22. Had problems with diarrhea/constipation?	☐	☐
23. Had mononucleosis in the past 12 months?	☐	☐
24. Have an orthodontic appliance being bought to clinic?	☐	☐
25. Have an absence of a paired organ?	☐	☐
26. Diagnosed with an emotional disorder?	☐	☐
27. Diagnosed with a psychiatric disease/disorder?	☐	☐

Please explain any yes answers, noting the number of the question:

_____
_____
_____

Is there any reason why this participant's activity should be restricted in any way?

_____
_____
_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely or for emergencies.

Daily/routine or emergency medications will only be administered by Medical Staff with this section completed.

☐ **This person takes NO Medication on a routine or emergency basis.**

☐ **This person takes daily/routine medications as follows:**

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications

☐ **This person has a current prescription for emergency medication (e.g., Epinephrine Pen - bee stings)**

Medication #1 _____ Reason for taking _____

Medication #2 _____ Reason for taking _____

IMMUNIZATION

COMPLETE IMMUNIZATION RECORDS are required for camp/clinic attendance. A copy of your child's immunization history from your pediatrician *MUST* be submitted prior to your child being able to attend/participate in camp/clinic.

Which of the following has the participant had?

- ☐ Measles
- ☐ German measles
- ☐ Hepatitis A
- ☐ Hepatitis C
- ☐ Chicken pox
- ☐ Mumps
- ☐ Hepatitis B

ALLERGIES: List all known. Describe reaction and management of the reaction.

Medication allergies (list)
1._____ _____
2._____ _____
3._____ _____

Food allergies (list)
1._____ _____
2._____ _____
3._____ _____

Other allergies (list) please include insect stings, hay fever, asthma, animal dander, etc.
1._____ _____
2._____ _____

IMPORTANT

The following signature is required for participation in the Marist College Sport Camp/Clinic

Parent/Guardian Authorizations: This health history for _____ is correct and complete.
(name of participant)

The person herein described has permission to engage in all activities except as noted. I hereby give permission to the camp/clinic to provide routine healthcare and seek emergency medical/dental treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp/clinic to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the Health Director of the Marist College sport camp/clinic, or their designee, to secure and administer treatment, including hospitalization, for the person named above.

Indemnification: The undersigned parent/guardian of the registrant, for and in further consideration of the Marist College sport camp/clinic, accepting said registrant, hereby agrees to save and indemnify and keep harmless the said Marist College sport camp/clinic, its' agents and sponsors against any and all liability, claims, judgments or demands arising as a result of any course of instruction or activity given the registrant by the Marist College sport camp/clinic.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____