 **Rob Koll’s C-Brand Wrestling Camp 2018** 33 Waterview Heights Road \* Ithaca, NY 14850
 **Phone:** (607) 255-9118 **E-Mail:** cbrandwrestlingcamps@gmail.com

Rm#\_\_\_\_\_\_
Counselor:\_\_\_\_\_\_\_

Camp Medical Form

Camp: Cornell University (Intensive Camp) June 24-28, 2018 \_\_\_\_\_\_\_\_\_\_\_
 Cornell University (Technique/Competition) June 25-28 \_\_\_\_\_\_\_\_\_\_
 Cornell University (Team Camp) June 25-28\_\_\_\_\_\_\_\_\_\_\_\_
 Brockport College (Intensive Camp) July 8-11 \_\_\_\_\_\_\_\_\_\_\_
 Brockport College ( Team Camp/Competition) July 8-11 \_\_\_\_\_\_\_\_\_\_

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City:\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_
Age:\_\_\_\_\_\_\_\_\_ Campers Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent/Guardian Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**1. Name of Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Daytime Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your child require any specific medical or other accommodations while attending camp? No: \_\_ Yes:\_\_
Please specify if yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Release:**I authorize the above named Physicians staff to discuss my child’s medical health and treatment needs with the Rob Koll’s C-Brand Wrestling Camps medical staff and/ or the medical support staff of any local emergency staff from \_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_, 2018.
Parents Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:** This is **REQUIRED.**  Please be sure **ALL** information is **CURRENT** and **ACCURATE**.
Name of Medical Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/ Guardian Statement:**I hereby authorize the staff of Rob Koll’s C-Brand Wrestling Camps and/ or the medical support staff or any area emergency facility to act for me according to their best judgement in any emergency requiring medical attention for my child.

Signature of Parent/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART TWO:
Camper Medical History Information**

**This is required information. Be sure ALL information is CURRENT and ACCRATE.
Form must be signed by a licensed health care professional OR a copy of Campers last physical exam within 24 months must be attached.**

1. Dates of Immunizations: (May attach a copy of records from Doctor’s Office\_
Dtap: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ 3. \_\_\_\_\_\_ 4. \_\_\_\_\_\_ 5. \_\_\_\_\_\_
Hep B: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ 3. \_\_\_\_\_\_
Hib: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ 3. \_\_\_\_\_\_ 4. \_\_\_\_\_\_\_
Polio: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ 3. \_\_\_\_\_\_ 4. \_\_\_\_\_\_\_
PCV: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ 3. \_\_\_\_\_\_ 4. \_\_\_\_\_\_\_
MMR: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ or Measles: \_\_\_\_\_\_ Mumps: \_\_\_\_\_\_ Rubella: \_\_\_\_\_\_

Varicella: 1. \_\_\_\_\_\_ 2. \_\_\_\_\_\_ OR Date of Dx Disease: \_\_\_\_\_\_\_\_\_
2. Normal Pulse Rate \_\_\_\_\_\_\_\_\_ Normal Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_
3. Allergies: Reaction: Medications to Treat: Epi-Pen:
\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_
4. Medications Camper will be taking during the stay: (Include all prescriptions and over the counter medications including inhalers. MUST have a medication order signed by a licensed physician with self-carry order when necessary.)

NAME: Dosage: HOW OFTEN: DIGNOSIS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (**ALL** medications **MUST** be in original container and **NOT** expired)
Does the camper administer own medication? Yes: \_\_\_ No: \_\_\_ Self-Carry? Yes: \_\_\_\_ No: \_\_\_\_
5. Medical History:History of concussion: Yes: \_\_\_\_\_ No: \_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
History of skin Condition: Yes: \_\_\_\_\_ No: \_\_\_\_ Date and Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(If currently under treatment for a non-contagious skin condition, documentations should be provided from the treating physician)
Cardiac History or Treatment:Yes: \_\_\_\_ No: \_\_\_\_ Self: \_\_\_\_ Family Hx: \_\_\_\_\_\_
6. List any Muscular-Skeletal Injuries or Diseases. List any necessary treatment procedures.
(Include any bone fractures, surgeries, muscle strains/sprains)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Does the camper require any special dietary alternative: Yes: \_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Physician ( print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_