



Summer Camp Medical Form

Parent or Guardian, please complete front page. Return no later than two weeks before camp begins.

Player Name: _____ Date of Birth: _____ Age: _____ Gender: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Mother/Guardian's Name: _____ Father/Guardian's Name: _____
 Address: _____ Address: _____
 City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
 Home Phone:(_____) _____ Home Phone:(_____) _____
 Work Phone:(_____) _____ Work Phone:(_____) _____
 Name of Emergency Contact other than parent/guardian listed above: _____
 Home Phone:(_____) _____ Work Phone:(_____) _____

Please keep camp informed of other address and phone numbers where you can be reached if you will be traveling while you child is at camp.

Player's Primary Care Physician's Name: _____ Phone:(_____) _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of player's most recent physical examination: _____
 Name of Family Dentist/Orthodontist: _____ Phone:(_____) _____

MEDICAL INSURANCE INFORMATION IF YOU HAVE A CARD OR FORM PLEASE PROVIDE A COPY

Subscriber Name		Social Security #	
Carrier Name		Carrier Address	
Group Name		Group Number	

Does your insurance require notification prior to emergency care or appointment with non primary care physician? _____
 Has your player ever required psychiatric counseling? Explain: _____
 Dates of operations and serious illnesses: _____
 Disability or chronic or recurring illness: _____
 Activities encouraged or limited by a physician: _____
 Dietary Modifications: _____
 Current Medications: _____

Please list other diseases, allergies to medication or health information you wish our health care provider to know:

Please read, understand, and sign the following release, indemnity, and authorization for treatment.
 I consent to the aforementioned player participating in any Winchester Basketball Association programs or activities. I acknowledge that participation in camp activities has inherent risk. I, the undersigned parent or guardian, assume that risk on behalf of my child and will indemnify and hold harmless the WBA from and against all claims and demands on account of, or in any way from, any accidental occurrence. In the event that my child should need further medical treatment while at camp, I give the camp medical staff permission to order x-rays, routine tests, treatments that may require hospitalization, and necessary transportation. I give the camp medical staff permission to administer medication or treatment prescribed by the camp's local physician should this become necessary. I understand that the camp medical staff may be unable to contact me at the time when medical treatment is necessary and therefore grant permission for them to seek and administer such treatment and medication prior to contacting me for further permission. I authorize payment of medical benefits to the health care provider for any necessary services and the release of any medical or other information necessary to process claims for visits incurred. In addition, I give the camp medical staff permission to administer other over-the-counter medications they deem necessary. I confirm that, to the best of my knowledge, my child is not allergic to any medications other than those listed above. This completed form may be photocopied. I have read the above and understand its meaning.

Printed name of Parent/Guardian _____
 Signature of Parent/Guardian: _____ Date: _____
 Witness: _____ Date: _____

Name: _____

Medical History: To be completed by a Physician. A Certificate of Immunization is to be attached. This form must be fully completed before sending to camp. This is the only form approved by the local Board of Health. It meets local regulation requirements.

* = Required for players and staff under 18 years old

** = Required for both staff and players

Immunizations	Dates	Immunizations	Dates	Immunizations	Dates	Special	Dates
Polio Vaccine* (TOPV) or (e-IPV)		MMR** (combined) Measles, Mumps, and Rubella		Adult Type Toxoid** (Td) Tetanus/ Diphtheria (if more than ten years have elapsed since last dose)		Tuberculin Screen**	
Hepatitis B* (if born after 1/1/92)		DTP** Diphtheria, Tetanus, and Pertussis		Other:		Other:	

Please indicate the medical conditions below that your child has experienced and give approximate dates.

	Date		Date		Date		Date
Accidents		Ear Infections		Measles		Rubella	
Allergies		Encephalitis		Meningitis		Scarlet Fever	
Bleeding Disorder		German Measles		Mononucleosis		Scoliosis	
Chicken Pox		Heart Disease/Defect		Mumps		Strep Throat	
Congenital Anomaly		Hernia		Operations		Tonsillitis	
Convulsions		Hypertension		Poliomyelitis		Tuberculosis	
Diabetes		Kidney Disease		Rheumatic Fever		Whooping Cough	

Please list any allergies including reaction and treatment: (drugs, food, environment, poison ivy, insect stings, other):

Please specify any dietary restrictions: _____

Current Medications : _____

Other medical conditions that may affect the player's activities while at camp: _____

Physician's Examination: Age: _____ Blood Pressure: _____ / _____ Pulse: _____ Height: _____ Weight: _____
Physical Development: _____

I have completed the above and have examined the individual. In my opinion, the condition of the person listed above does not preclude his/her participation in an active camp program. I have screened the individual for signs of active tuberculosis.

Licensed Physician's Signature: _____

Address: _____ Phone: (____) _____

Date of form completion: _____ By (initial if completed by nurse or physician's assistant): _____

Date examined by camp nurse: _____ Initials: _____

Please Note: According to Commonwealth of Massachusetts Law, we may not admit any child to camp without this completed medical form. The front page must be completed by the player's parent/guardian including the signed authorization for treatment. This side must be completed by a physician. The player must have been examined by a physician within 24 months year prior to his/her stay at camp. All players must have a record of immunizations meeting the Massachusetts immunization requirements for children attending recreational camps. For more information please contact your physician.