ALL ISLAND BASKETBALL CAMP MEDICAL CLEARANCE FORM

I. TO BE COMPLETED BY A PARENT

Camper's Name		DOB	Sex ☐Male ☐Female	
Address		City/State	Postal Code	
Emergency Contact #1	Name: Relationship:	Home #:	Cell #:	Work #:
Emergency Contact #2	Name: Relationship:	Home #:	Cell #:	Work #:
Allergies (please list)				
Health History	☐Mumps ☐German Measles ☐Measles ☐Diabetes ☐Rheumatic Fever ☐Epilepsy			
Operations or serious injuries		Disabilities or chronic illness		
Dietary problems or modifications		Current Medication		

PARENT AUTHORIZATION: I certify that the individual named above is in good physical condition and is capable of taking part in all camp activities. If medical attention beyond first-aid treatment is required, I understand that every attempt will be made to contact me at the emergency number provided. If contact with me is not possible I give permission for emergency transport and medical attention to be administered.

Parent's Signature _____ Date _____

II. TO BE COMPLETED BY A PHYSICIAN

Height	Weight	Blood Pressure	HgB	UA	
Eyes	Heart	Extremities	Ears	Throat	
Hernia	Lungs	Skin	Nose	Abdomen	Posture
Any physical disabilities?					
Are there any medications to be administered at camp?	☐No	☐Yes Specify_____ Dose_____ Allergies_____			
Restricted Activities					

Please attach a signed/stamped copy of the most recent immunization record.

PHYSICIANS AUTHORIZATION: I have examined the above named camper. It is my opinion that he or she may participate in all activities, except as noted.

Physician signature_____ Date _____

Phone number (_____)_____ Address _____