



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: <i>(Dates for each dose)</i>	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 <i>(Please check)</i> _____	

Weight _____ Height _____ BP _____

Yes No (Please Check if Applicable)

Asthma: Mild Moderate Severe Exercise Inducer

Allergies: Medication Food Seasonal Other _____

Anaphylactic Reaction: Insect Food Latex

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

Diabetes: Type I Type II

Seizure Disorder

(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)* _____

General Health History that applies to this individual

Yes No

Any recent injury, illness or infectious disease?

Have a chronic or recurring illness?

Ever been hospitalized?

Ever had surgery?

Have frequent headaches?

Ever have a head injury:

Ever been knocked unconscious?

Wear glasses, contacts?

Ever had frequent ear infections?

Ever passed out during or after exercise?

Ever been dizzy during or after exercise?

Ever had seizures?

Ever had chest pains during or after exercise?

Ever had high blood pressure?

Ever been diagnosed with a heart murmur?

Ever had back problems?

Ever had problem with joints? (i.e. knee, ankle)

Have an orthopedic appliance for camp?

Have any skin problems? (i.e. acne, rash)

Had mononucleosis in the past 12 months?

Had problems with diarrhea/constipation?

Have problems with sleepwalking?

Have a history of bed-wetting?

Ever had an eating disorder?

Ever had emotional difficulties for which

professional help was sought?

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

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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)

*****Is there anything else you think might be helpful to us in caring for this player? If yes, please attach an explanatory letter. PLEASE NOTIFY US IF ANY MEDICAL TREATMENT OR PROGRAM WILL CONTINUE DURING THIS STAY.**

Required MUST BE FILLED OUT

EMERGENCY INFORMATION: (If parents cannot be reached)

NAME _____ RELATIONSHIP _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE # _____ EMAIL ADDRESS _____

Required MUST BE FILLED OUT

INSURANCE INFORMATION:

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*