SELECTS Sports

Section I: General Information

This Form is to be completed by a parent or guardian. Every section must be filled in completely. Please write N/A if not applicable. Do not leave blanks.

Participants Information

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Gender:** _____

Primary Phone: _____ **Type:** _____

Secondary Phone: _____ **Type:** _____

Email: _____

Address: _____

City: _____ **State:** ____ **Zip Code:** _____
United States Residents Only

Country: _____ **Province:** ____ **Postcode:** _____
Canadian Residents Only

Parent/Guardian 1 Information

Full Name: _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Address: _____

City: _____ **State:** ____ **Zip Code:** _____
United States Residents Only

Country: _____ **Province:** ____ **Postcode:** _____
Canadian Residents Only

Parent/Guardian 2 Information

Full Name: _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Address: _____

City: _____ **State:** ____ **Zip Code:** _____
United States Residents Only

Country: _____ **Province:** ____ **Postcode:** _____
Canadian Residents Only

Section II: Emergency Notification

Specify an individual to be notified if above parents/guardians aren't available. This person may NOT be an individual listed above or at the same residence. Parent/guardian contacts will be attempted first.

Full Name: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Address: _____

City: _____ **State:** ____ **Zip Code:** _____
United States Residents Only

Country: _____ **Province:** ____ **Postcode:** _____
Canadian Residents Only

Section III: Immunization Record

Participants cannot be admitted to the program without the immunization dates being filled in completely. Writing “up to date” is not acceptable.

DTP:

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____

Tetanus/Diptheria (DT):

1. _____

OPV (Polio):

1. _____ **2.** _____ **3.** _____ **4.** _____

Measles:

1. _____ **2.** _____

Mumps:

1. _____ **2.** _____

Rubella:

1. _____ **2.** _____

Hepatitis B:

1. _____ **2.** _____ **3.** _____

Varicella (Chicken Pox)

1. _____ **2.** _____

Haemophilus Influenza

1. _____ **2.** _____ **3.** _____ **4.** _____

List if the participant has ever had Measles, Mumps, or Chicken Pox? _____

Date of last TB Test: _____ **Positive/Negative:** _____

Section IV: Health Insurance

Health insurance is required for ALL participants. Insurance claims are handled by the family and the respective insurance company.

Insurance Company: _____ **ID #:** _____

Subscribers Name: _____ **Group #:** _____

City of Company: _____

Relationship of Participant to Subscriber: _____

Section V: Health History and Medications

Please answer each of the following questions (yes/no) and elaborate in the spaces provided.
Does the participant have (or ever had) the following?

Allergies:* _____

Explain: _____

**If yes, will he/she need an allergy injection during the duration of camp participation?* _____

Asthma: _____

Explain: _____

ADHD: _____

Explain: _____

Diabetes: _____

Explain: _____

Dietary concerns/restrictions: _____

Explain: _____

Epilepsy: _____

Explain: _____

Physical Disabilities: _____

Explain: _____

Major Illness/condition: _____

Explain: _____

Mental/psychological Illness: _____

Explain: _____

Glasses/contact lenses: _____

Explain: _____

Other Pertinent Medical History: _____

Explain: _____

If female, has she begun menstration? _____

All medications must be given to the Medical Director for dispensing, including over-the-counter medications. The only exceptions to this will be Epi-pens and inhalers used as needed for asthma attacks (ie: albuterol). Keep each medication in the original packaging/bottle that identifies the prescribing doctor (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Please list any medications (prescription and/or over-the-counter) the participant will be bringing to camp. (Name, Dose , Frequency, Reason, Name and phone # of prescribing doctor)

_____

_____

_____

Section VI: Parent/Guardian Authorization

This health history is correct to the best of my knowledge, and the individual listed on this form has permission to engage in all prescribed program activities, except as noted by me. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give my permission for routine medical treatment of illness and injury at Millard-Fillmore hospital or other, by a certified athletic trainer or licensed physician, and for routine emergency medical treatment at Millard-Fillmore hospital or other Medical Center if referred by the camp medical director.

I certify that the above information is true and correct and to submit the healh form: ☐