5 West Olive Plaza
Scranton PA 18508
670-498-1071

Backcourt Hoops Skills Camp Medical Form

MUST BE RETURNED AT CHECK-IN
1st Day of Camp Registration

Camp Session Attending:_____

IMPORTANT!
MUST BE BROUGHT TO CAMP & SIGNED BY A PHYSICIAN, PARENT & CAMPER

Name_____Date of Birth_____Sex___Age___
Parent/Guardian_____Home Phone( )_____Work Phone( )_____
Home Address_____City_____State_____Zip_____

IF NOT AVAILABLE IN ANY EMERGENCY, NOTIFY:
Emergency Contact_____Phone ( )_____
Emergency Contact_____Phone ( )_____
Name of Family Doctor_____Phone ( )_____
Allergies/Medications_____
Special Conditions_____
Insurance Company_____Policy No._____Group No._____

MUST BE COMPLETED FOR ATTENDANCE

PARENT'S AUTHORIZATION: This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give my permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child and in the event I cannot be reached in an emergency. I understand that basketball is a physical activity and a contact sport. Backcourt Hoops has informed me that during this activity, there is a possibility of serious injury or death. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I also understand that we are responsible to have coverage with Blue Cross, Blue Shield or another commercial insurance carrier. I also waive
JB Hoops Inc.Backcourt Hoops of any responsibility to pay for hospital bills or insurance expenses.

Signature of Parent/Guardian_____Date_____

The camper and his/her parents agree to abide by the rules and regulations set up by the Camp for health, safety and welfare of the Camp. The following violations of camp rules will result in immediate dismissal from the camp without refund of camp fee:

1) Leaving campgrounds without permission.
2) Willful destruction of camp property.
3) Use of drugs and/or alcoholic beverages.
4) Fighting and/or continued insubordinate behavior resulting in disrupting of the camp program.

Camper's Signature_____Date_____

If it is necessary, in the judgment of the camp, to use outside medical, surgical or dental aid for the camper's health, all such expenses shall be paid by the parent, unless covered by parent or guardian's insurance. The camp is not responsible for articles of clothing or personal belongings lost or damaged by theft, laundry or otherwise except if accepted by the camp director personally for safekeeping. If the parent cannot be reached in case of emergency, the camp is authorized to use its own judgment in any situation. The camp is given permission to use all pictures taken during my child's stay at camp for any advertising. The parent gives permission to Backcourt Hoops for the son/daughter to travel in all licensed camp vehicles during the course of the regular camp session. This also includes buses that are used on rainy days to our other indoor facilities.

Signature of Parent/Guardian_____Date_____

MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

Name_____Social Security #_____
Height_____Weight_____Blood Pressure_____Pulse_____

Check any positive answers:

HEAD ___Concussion___Severe or migraine headache___Dizziness___Nosebleeds
SKIN ___Severe acne___Boils___Recurring rashes
EYES ___Loss of vision___Double vision___Detached retina___Contact lens___Glasses
NECK ___Numbness of arms or legs___Stiff neck___Wry neck
TEETH ___Bridge work___Dental plates___Sever caries___Orthodontic appliances
THROAT____Frequent sore throat___Tonicities
EARS ___Ruptured eardrum___Abscess___Draining ear_Hearing Loss
CHEST ___Deformity___Pain___Heart murmurs___Shortness of breath___Coughing up blood
ABDOMEN ___Cramps or pain___Vomiting___Rupture
___Bloody diarrhea___History of bloody urine___Sugar in the urine
MALE ___Genitourinary disorders___Removal of kidney___Undescended___Other
FEMALE_____Gynecological disorders___Removal of kidney___Ovarian cyst___Menstrual cycle
SPINE ___Scoliosis___Operations___Pain
EXTREMITIES ___History of varicose veins___Severe flat feet

Have you ever had: (circle yes or no)			Digestive Condition	yes	no
Pneumonia	yes	no	Diabetes	yes	no
Rheumatic Fever	yes	no	Kidney Disease	yes	no
Scarlet Fever	yes	no	High Blood Pressure	yes	no

List any other conditions no listed above:_____
_____
History of Surgical Operations:_____
_____
Date of last tetanus shot:_____
Athletic injuries previously sustained:_____
_____
Do you require any special equipment to participate?_____
Doctor's comments:_____
_____
_____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Signature of Examining Physician_____Date_____