



PO BOX 633
YARMOUTHPORT, MA 02675
(617) 899-5433



Camper Medical Report

(Report must be completed and submitted prior to the start of the camp)

_____ DOB ____/____/____ was examined on ____/____/____
and was found to be in good health and able to participate in school/daycare/camp or athletic activities.

Restrictions: _____

The parent/guardian, by his/her signature, deny any significant health problems have occurred since the above date.

Parent/Guardian Signature **Date** **Physician/Provider Signature** **Date**

This form, if signed by both parent and physician is valid for up to one year from the date of the exam and can be copied for further use during this period.

Immunization Record:

DPT/Dtap	OPV/IPV	Scoliosis Check _____	
1.	1.	Allergies	
2.	2.	HCT	Lead(Pb)
3.	3.	UA	TB
4.	4.	Ht.	Wt.
5.	5.	BP	Pulse
TD			
MMR	Hep B	Hib	Varivax
1.	1.	1.	1.
2.	2.	2.	2.
		3.	
		4.	
Pprevnar: 1.	2.	3.	4.
Chicken Pox			

Pertinent Medical Information:

IMPORTANT: Has this camper been exposed to any communicable disease within the last six months?

Yes No (If Yes,, state type and date of exposure _____)

HEALTH HISTORY: (Check, giving approximate dates)

Ear Infections	Allergies:	Diseases:
Rheumatic Fever	Hay Fever	Chicken Pox
Convulsion	Ivy Poisoning, etc.	Measles
Diabetes	Insect Stings	German Measles
Behavior	Penicillin	Mumps
Asthma	Other Drugs	Other Contagious Diseases
Other	Past	Illnesses _____
Operations or	Serious	Injuries (Dates) _____
Hospitalization (Dates) _____		
Chronic or Recurring Illness _____		
Any specific activities to be encouraged? _____		
Conditions that require activity to be restricted? _____		
Permission for all program activities unless otherwise noted by Dr: _____		
Appliance worn (glasses, contacts, etc.) _____		
Medication taken _____		
Suggestion from Parent/Guardian) _____		

Consent for Emergency Medical Treatment

***** THIS FORM MUST BE SIGNED FOR FULL PARTICIPATION *****

By enrolling player, I ensure that such individual is physically and mentally able to participate in all of the camp's activities. I understand HOOP GROUP, INC and its related camps, its shareholders, directors, officers, employees, representatives, independent contractors, the property where the session is held and any or all of its officials cannot be held responsible in whole or in part for any accidents resulting in medical or dental expenses incurred from participation in the program and I release each of them from and against any other claims, costs, liabilities and injuries incurred while at the camp. I agree to assume full and complete responsibility for any and all medical bills resulting from player's participation. In the event of an emergency, I authorize the camp to exercise its' judgment in the treatment of said player by a medical authority.

I do hereby give authority to the Hoop Group, Inc. and its staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature of Parent or Guardian *Relationship*

Date ____/____/____

Telephone(____)____-_____