Hoop Mountain Midwest Basketball

MEDICAL and INSURANCE INFORMATION FORM

ATTENDEE's NAME: ____

HOOP MOUNTAIN EVENT: ____

ATTENDEE INFO -

DATE OF BIRTH: ______/______/__________ HEIGHT: ________________ WEIGHT: _________________

HOME STREET ADDRESS: ____

CITY: ____ STATE: __________ ZIP: _______________

EMERGENCY CONTACT- ____

RELATIONSHIP TO ATTENDEE: ____

STREET ADDRESS: ____

CITY: ____ STATE: __________ ZIP: _______________

HOME PHONE: (_____) -______-__________ OFFICE PHONE: (_____) -______-__________

CELL PHONE: (_____) -______-__________

IF UNABLE TO REACH THE ABOVE CONTACT, NAME & PHONE NO. OF ANOTHER RESPONSIBLE PERSON:

NAME: ____ PHONE: (_____) -______-__________

FAMILY PHYSICIAN- ____

OFFICE PHONE: (_____) -______-__________

DATE OF MOST RECENT PHYSICAL EXAM: ______/______/__________

DATE OF MOST RECENT TETANUS BOOSTER: ______/______/__________

LIST ANY **ALLERGIES** THAT ATTENDEE HAS:

1.______________________________________ 2.______________________________________

3.______________________________________ 4.______________________________________

LIST ANY **MEDICATIONS** THAT THE ATTENDEE IS CURRENTLY TAKING:

1.______________________________________ 2.______________________________________

3.______________________________________ 4.______________________________________

IMPORTANT: IF THE ATTENDEE IS CURRENTLY TAKING MEDICATION, IT IS IMPERATIVE THAT HE BRING IT WITH HIM AND ADVISE THE TRAINER OF THE MEDICATION.

HAS THE ATTENDEE HAD ANY OF THE FOLLOWING? CHECK ANY THAT APPLY. FOR ANY THAT APPLY PLEASE PROVIDE AN EXPLANATION. (SEND ADDITIONAL INFORMATION IF APPROPRIATE)

ASTHMA		HEART CONDITION		SEVERE SPRAINS	
BLEEDING DISORDER		HEAD INJURIES		SURGERIES	
EPILEPSY		KIDNEY DISEASE		FRACTURES	
DIABETES		HEAT/EXERCISE RELATED DIZZYNESS/SHORTNESS OF BREATH			

EXPLANATION: ____

____

____

INSURANCE INFORMATION – INSURANCE POLICY UNDER WHICH ATTENDEE IS COVERED.

INSURED'S NAME: ____

NAME OF COMPANY: ____

POLICY/IDENTIFICATION NUMBER: ______________________________ GROUP NUMBER: ____________

CONTACT PHONE NUMBER(s): 1. (_____) -______-__________ 2. (_____) -______-__________

PARENT'S OR GUARDIAN'S AUTHORIZATION

THIS HEALTH HISTORY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THAT THE ATTENDEE IS IN GOOD HEALTH AND THERE ARE NO RESTRICTIONS OR LIMITATIONS WHICH WOULD AFFECT HIS ABILITY TO PARTICIPATE IN THE PHYSICAL ACTIVITY OF A VIGOROUS ATHLETIC PROGRAM.

IN THE EVENT OF AN EMERGENCY, I HEREBY GIVE PERMISSION TO HOOP MOUNTAIN MIDWEST STAFF, AS DEEMED NECESSARY, TO HOSPITALIZE AND TO AUTHORIZE TREATMENT BY THE PHYSICAN SELECTED FOR THE ATTENDEE WHILE HE IS PARTICIPATING IN ANY EVENT SPONSORED BY HOOP MOUNTAIN MIDWEST BASKETBALL.

SIGNATURE:____ DATE:____________________

RELATIONSHIP TO ATTENDEE: ______________________________________