



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 PHYSICIAN SELECTED FOR THE ATTENDEE WHILE HE IS PARTICIPATING IN ANY EVENT SPONSORED BY HOOP MOUNTAIN MIDWEST BASKETBALL.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO ATTENDEE: _____