

# BORO BUILT WRESTLING CAMP MEDICAL HISTORY AND CONSENT FORM

Please print in ink

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Camp \_\_\_\_\_ Date of Camp \_\_\_\_\_

## PARENT OR GUARDIAN

Name \_\_\_\_\_ Cell Number (\_\_\_\_\_) \_\_\_\_\_ Work Number(\_\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Agreement Number \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

I, the guardian, have medical insurance coverage for my son/daughter and understand that I am responsible for all medical costs associated with injuries, infections, accidents and illnesses that may occur at camp.

## EMERGENCY PHONE NUMBERS

1<sup>st</sup> Choice Name \_\_\_\_\_ Cell #(\_\_\_\_\_) \_\_\_\_\_ Other # (\_\_\_\_\_) \_\_\_\_\_

2<sup>nd</sup> Choice Name \_\_\_\_\_ Cell #(\_\_\_\_\_) \_\_\_\_\_ Other # (\_\_\_\_\_) \_\_\_\_\_

## MEDICAL HISTORY OF CAMPER

1. Any current medical problems? NO YES  
If yes, \_\_\_\_\_

2. Had any recent injury requiring medical attention? NO YES  
If yes, \_\_\_\_\_

3. Currently taking medication? NO YES  
Please list \_\_\_\_\_

4. Had any severe head or neck injuries? NO YES

5. Had any major surgical operations? NO YES

6. Had any chronic illness (epilepsy, diabetes, heart disease)? NO YES  
If yes, \_\_\_\_\_

7. Any allergies to prescription and/or non prescriptions medication? NO YES  
Please list \_\_\_\_\_ Reaction \_\_\_\_\_

8. Any additional allergies (food, insect, etc.) NO YES  
Please list \_\_\_\_\_

Please explain any yes answers \_\_\_\_\_

Date of last tetanus Immunization \_\_\_\_\_ Name and telephone of Medical Provider \_\_\_\_\_

I, the guardian, have medical insurance coverage for my son/daughter and understand that I am responsible for all medical costs associated with injuries, infections, accidents and illnesses that may occur at camp.

## PARENTAL CONSENT TO MEDICAL TREATMENT

**PLEASE SIGN** the following statement concerning the medical treatment of my child:

\_\_\_\_\_ In the event of any illness or injury to my child I give the medical provider permission to administer treatment, while continuing to contact the parent, guardian or designated individual.