TO BE COMPLETED BY PARENT OR GUARDIAN OF CAMPER

Camper Name: _____
Camp Attending: _____ Date of Birth: _____

MEDICAL INSURANCE INFORMATION

Do you have health insurance? [ ] YES [ ] NO
Insurance Company: _____ Insurance Phone: ( ) - Group Name:_____
Policy Holder Name: _____ Insurance Policy Number: _____ Date of Coverage: _____
Other Information: _____

Please complete the following and list any information and/or necessary treatments or medications that will assist our staff of athletic trainers.

Please list any health problems, allergies, or barriers to learning, or behavioral issues we should be concerned with including previous significant injuries, current medical treatment, and/or allergies to medications: (Please use back page if necessary)

List all medications the camper takes, the frequency, and purpose of each medication (attach additional page, if necessary):

Medication Name	Frequency	Purpose of Medication

EMERGENCY AND OTC MEDICATION CONSENT FOR CAMP

I hereby give my consent to emergency medical treatment and to assist with the management of prescription medication in accordance with prescription instructions. per standing orders:

Treatment:	Initials:	Treatment:	Initials:
Acetaminophen (Tylenol) for pain or fever*		First Aid & Wound Care OTCs (Neosporin, Band-Aids, etc.)	
Ibuprofen (Advil, Motrin) for pain or inflammation*		Consent to EMS care and transport, should it be necessary.	
Diphenhydramine (Benadryl) for allergic reactions*		Assist with the management of prescription medication in accordance with prescription instructions.	

*Dosages will be administered according to the manufacturer's guidelines unless otherwise specified by a healthcare provider.

When was the camper's last tetanus shot? _____/20____ (month/year)

NJ and MA camps/academies **must** also include a copy of the participant's immunizations.

PRIVACY STATEMENT & ACKNOWLEDGEMENT

Subject to HIPAA and state laws, medical information provided is confidential and disclosed only to authorized personnel or as required by law. By signing, you consent to this use and disclosure. You may revoke consent in writing at any time. As the parent/guardian of the named child, I've provided accurate information and will upload a signed form and recent physical. I consent to medical treatment for my child during camp if needed. If I am unreachable in an emergency, I authorize treatment.

Parent/Guardian Signature: _____ Phone: _____
Print Name: _____ Email: _____ Date: _____

Please upload the completed form to your account online *prior* to the start of camp. If you are unable to upload you may also mail to:
Attn: Sports International, 207 Tillbrook Lane, Harrison City, PA 15636
Please postmark 30 days before camp start. While you can bring this form to camp, we recommend completing and uploading it online beforehand.

MEDICAL ELIGIBILITY – SECTION MUST BE COMPLETED BY A MEDICAL PROFRESSIONAL

I have examined the camper named on this form and conducted a pre-participation physical. The camper is medically cleared as follows for football camp. If new conditions arise, I may revoke this clearance until issues are resolved and fully explained to the athlete and guardians.

- ☐ Full Participation
- ☐ **Limited Participation
- ☐ No Participation

**If Limited Participation, please provide details: _____

Signature of health care professional: _____, MD, DO, NP, or PA Date:_____

Adapted from the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL – PHYSICAL EXAMINATION FORM

A copy of a current physical (within 12 months from the start of camp) may be attached in place of the below but a licensed M.D. or D.O. MUST Complete and sign the Eligibility section on page 1.

Camper Name: _____ Date of birth: _____

EXAMINATION		
Height: Weight:		
BP: / (/) Vision: R 20/ L 20/ Corrected: □ Y □ N Pulse:		
MEDICAL	**NORMAL**	**ABNORMAL**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat Pupils equal Hearing		
Lymph nodes		
Heart Murmurs[a] (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin: Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional: Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: (_____)_____

Signature of health care professional: _____, MD, DO, NP, or PA

**** Page 1 of the Medical Authorization Form must be signed by a physician under the "medical eligibility" section****