

EMERGENCY MEDICAL INFORMATION

This form must be completed and returned prior to your child's participation in the camp. This form should be returned to: Ronnie Arrow Basketball Camps, University of South Alabama, 1273 Mitchell Center, Mobile, AL 36688-0002.

CAMP: Ronnie Arrow's Boys Basketball Camp Dates: _____

CAMPER'S NAME: _____ BIRTH DATE: _____

PARENT/GUARDIAN NAME(S): _____

Home Ph#: () _____ Work Ph#: () _____ Cell#: () _____

Address: _____
(Street) (City) (State) (Zip Code)

EMERGENCY CONTACT: _____

Home Ph#: () _____ Work Ph#: () _____ Cell#: () _____

Health Information Statement

Check below any health conditions that relate to camper. In space below, please provide information relating to condition checked. In case of emergency, this health information may be the only source of accurate medical information. This information is confidential.

- | | |
|--|--|
| <input type="checkbox"/> Mental or emotional health issue (epilepsy, emotional stress, convulsion, etc.) | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Lung Disease (asthma, persistent cough, TB) | <input type="checkbox"/> Disease of Heart or Blood Vessels, Abnormal Blood Pressure |
| <input type="checkbox"/> Chest pains or shortness of breath (heart murmur, rheumatic fever) | <input type="checkbox"/> Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis) |
| <input type="checkbox"/> Arthritis, Diabetes, Kidney, or Bladder Disease | <input type="checkbox"/> Hay Fever or Allergies |
| <input type="checkbox"/> Impaired vision or hearing, Chronic ear infections | <input type="checkbox"/> Recent surgeries, accidents or injuries |
| <input type="checkbox"/> Any current skin disease | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Health related issues not listed | <input type="checkbox"/> Significant Orthopedic and/or Neuromuscular impairment |

Explanation: _____

Please Note: All medications that accompany the camper to camp must be given to the Athletic Trainer. The Trainer will dispense the medication in accordance with the directions provided by the camper. All authorized over-the-counter and prescription medication should be listed below.

Allergies to what medicines? _____

Current Prescription/Non-prescriptions medicines (list names, doses, times) _____

Special instructions for handling of medicines _____

Family Doctor _____ Phone # () _____

Health Insurance Provider _____ Policy # _____

As parent/guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However, if the Camp is unable to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I also understand that if my child becomes ill or injured, my health insurance will be the primary coverage for any expenses incurred. The University of South Alabama carries accident insurance that is secondary coverage in the event of an injury.

Signature: _____ Date: _____