



HEALTHY HISTORY & MEDICAL AUTHORIZATION FORM FOR ALL PERSONS UNDER THE AGE OF 18

Registration will NOT be processed unless it is accompanied by this form. NOTE: A doctor's signature is NOT required.

NAME OF CAMPER: _____
Last First MI Home Phone

Street Address _____
City State Zip

CAMPER'S SOCIAL SECURITY # _____ CAMPER'S DATE OF BIRTH _____

CAMPER'S GENDER: Male Female CAMPER'S AGE: _____ GRADE ENTERING AS OF SEPTEMBER 2016: _____

PARENT NAME: _____ Daytime Phone: _____

E-Mail Address: _____

PARENT NAME: _____ Daytime Phone: _____

E-Mail Address: _____

ALT. EMER. CONTACT: _____ Daytime Phone: _____

FAMILY PHYSICIAN: _____ Daytime Phone: _____

PLEASE COMPLETE THE FOLLOWING:

Withholding relevant physical, emotional and mental health history may result in exclusion from camp. Specify all known conditions such as ADD/ADHD in #1 below. A camper whose presence poses a continuing danger to persons or property, or an ongoing threat of disrupting the camp experience for others, will be excluded from activities and expelled from camp.

ALL MEDICATIONS INCLUDING INHALERS & EPI PENS, MUST BE STORED & WILL BE ADMINISTERED BY CAMP MEDICAL STAFF

- Currently under physician's care for: _____
- Current medication being taken (including medication taken during the school year): _____ NONE
- Were you ever advised not to allow this child to play in any sports? YES NO
- List any medical conditions: _____
- List any allergies including bee stings, hives, asthma _____
 Circle: Child uses epi pen / Child uses an inhaler (Indicate type) _____
 Child can use this independently YES NO
- Has this child:
 - had difficulty with sight? YES NO
 - had difficulty with hearing? YES NO
- Does this child have a history of fainting with exercise? YES NO
- Has child experienced recent loss of family member or close friend? YES NO

According to state law, all campers must be immunized or submit a statement indicating REFUSAL TO VACCINATE. Provide dates for each immunization. DO NOT attach additional pages of the health history record from your doctor's files. Only the dates of vaccination are pertinent. For a copy of the Refusal to Vaccinate form please call (732) 502-2255

Immunization For:	Dates of Vaccination (month/year):
Diphtheria, Tetanus, Pertussis (DTaP) or (TdaP)	_____
Mumps, Measles, Rubella (MMR)	_____
Pneumococcal (PCV)	_____
Hepatitis A	_____
Varicella (Chicken Pox)	_____
	Haemophilus Influenza Type B (HIB) _____
	Polio (IPV) _____
	Hepatitis B _____
	Meningococcal Meningitis (MCV4) _____
	Last TB/Tetanus Booster _____

RELEASE AUTHORIZATION

Children will only be released to individuals who are authorized. If you wish to have your child picked up by individuals not on this list, you must provide the camp with a revised authorization list 48 hours before pick-up date.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

If an emergency illness or injury occurs, I (parent/guardian) hereby authorize Hoop Group to treat and/or send this person to a physician or hospital and authorize the necessary treatment. I also authorize the physician or hospital to release my child after treatment to a representative of Hoop Group. All information on this form is complete, true and accurate to the best of my knowledge.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Hoop Group Headquarters Injury Waiver and General Release



MUST BE RETURNED PRIOR TO ANY PARTICIPATION AT HOOPGROUP HEADQUARTERS!

As a participant at Hoop Group Headquarters or any of its camps, clinics, tournaments or team events, I acknowledge that participation in any of said events exposes me to a possible risk of personal injury. I, hereby release Hoop Group Headquarters and any of its officers, directors, employees, agents, licensees, subsidiaries, consultants, independent contractors and affiliates from any and all liability for property damage, personal injuries or other claims arising from or in connection with my participation, including claims that are known and unknown, foreseen and unforeseen, future or contingent.

This release also gives Hoop Group the absolute and irrevocable right and permission with respect to the photographs/video that they have taken of me or in which I may be included with others. Hoop Group has the ability to use, to re-use, publish and republish in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not always by limitation) illustration, promotion, advertising and trade.

I covenant that I will not now or at any time in the future, directly or indirectly, commence or prosecute any action, suit or other proceeding against Hoop Group Headquarters and or any of its officers, directors, employees, agents, licensees, subsidiaries, consultants, independent contractors and affiliates, arising out of or relating to the actions, causes of action, claims and demands hereby waived, released and discharged by me.

I acknowledge that I have read and fully understand this Injury Waiver and General Release Form. This agreement will be binding on me, my spouse, my children, my legal representatives and my heirs, successors and assigns.

DATE: _____ PARTICIPANT: _____
Signature

Email _____ Printed Name _____

ADDRESS _____

The undersigned ("Parent"), or ("Guardian") of _____ ("Subject"), hereby consent to affirm, and, on behalf of subject, agree to be bound by the Injury Waiver and General Release Form attached hereto which has been signed by subject. Parents also represent, warrant and agree that Parents (is) (are) entitled to the care and custody of Subject and (is) (are) Subject's legal guardian(s); that during the minority of Subject and for a reasonable time afterwards, Parents will use all reasonable efforts to prevent Subject from attempting to or actually disaffirming the Injury Waiver and General Release Form signed by Subject; that Parents hereby acknowledge that Parents have read the Injury Waiver and General Release Form and are satisfied that it is fair and equitable for the benefit of Subject; and that Parents will not revoke this consent and approval.

DATE: _____ PARENT: _____
Signature

Printed Name _____

Cell Phone - _____



CAMP MEDICATION POLICY

It is the policy of Hoop Group to discourage children from taking medication while attending camp. However, if your child has a chronic health condition (e.g: seizure disorder, ADD, ADHD, Diabetes, epi pen, inhaler, etc.) or is presently being treated for an episodic illness which necessitates him/her taking medication during camp hours, please contact the Camp medical staff at 732-502-2255. This signed document and any medication the camper will be taking must be given to the medical staff prior to the start date of your child's camp.

All medication must be stored with the Camp medical staff. Medication will be administered only upon written order of the prescribing physician and at the request of the parent/guardian, giving permission to administer the medication and releasing the camp staff for ALL liability for administration of the medication as specified. Medication shall be given to Camp medical staff ONLY in a labeled prescription bottle.

Camper: _____

Diagnosis: _____

Medication name
&
Dosage: _____

Time to be given: _____

Signature of Physician

Date

I hereby give permission to the Hoop Group Medical staff to administer medication to my child as directed by the physician.

I release Hoop Group/Hoop Group medical staff of all liability for the administration of medication as specified above.

Signature of Parent/Guardian

Date



**SELF ADMINISTRATION - EPI PEN - INHALER - INSULIN ONLY
PERMISSION FORM – CHILD CANNOT SELF MEDICATE**

I, _____ parent/guardian of _____ am aware that my child can carry their own epi pen/inhaler with them while they attend camp. **I DO NOT WANT MY CHILD TO SELF MEDICATE.** My child will carry their epi pen/inhaler with them, but a second one will be stored with medical staff. My child’s medication will be administered only when necessary, by Hoop Group Camp medical staff and only upon written order to administer these emergency medications according to the physician’s directions and release Hoop Group medical staff from all liability for administering the medication as specified.

Camper Age Weight

Diagnosis: _____

Allergy: _____

Signature of Parent/Guardian Date

Please provide a second epi pen/inhaler/insulin to be kept with Camp medical staff in the event that your child forgets his/her medication. **Medication must be in a labeled prescription box or bottle.**

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PHYSICIAN PERMISSION

Camper Date

Diagnosis

Name of medication & Dosage

Instructions for administration

Signature of Physician Date



SELF ADMINISTRATION - EPI PEN - INHALER - INSULIN ONLY
PERMISSION FORM – SELF MEDICATING

I, _____ parent/guardian of _____
give permission for my child to carry _____
(name of medication)

My child is aware of the dosage and has been instructed on how to use the medication by our private physician and myself. My child understands those instructions and demonstrates proper use of the medication. My child is aware of situations that require further medical attention.

Camper Age Weight

Diagnosis: _____

Allergy: _____

Signature of Parent/Guardian Date

I understand that Hoop Group shall not incur any liability as a result of injury arising from my decision to permit my child to self-medicate.

Please provide a second epi pen/inhaler/insulin to be kept with Camp medical staff in the event that your child forgets his/her medication. **Medication must be in a labeled prescription box or bottle.**

PHYSICIAN PERMISSION

I have instructed both the parent and the child in the administration of _____
(name of medication and dosage) and feel that this child may carry the medication on their persons and self-medicate as needed.

Signature of Physician Date