



SUMMER (after June 1)  
381 Fetherman Road  
Stroudsburg, Pa 18360  
(570) 992-6343 (570) 992-5387 fax

YEAR-ROUND  
1930 Heck Ave., Bldg 3  
Neptune, NJ 07753  
(732) 502-2255 Fax (732) 502-9636

## Hoop Group Skills Camp Medical Form

### MUST BE RETURNED AT CHECK-IN 1<sup>st</sup> Day of Camp Registration

Camp Session Attending: \_\_\_\_\_

#### IMPORTANT!

MUST BE BROUGHT TO CAMP & SIGNED BY A PHYSICIAN, PARENT & CAMPER

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_  
Parent/Guardian \_\_\_\_\_ Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

#### IF NOT AVAILABLE IN ANY EMERGENCY, NOTIFY:

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Name of Family Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Allergies/Medications \_\_\_\_\_  
Special Conditions \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

#### MUST BE COMPLETED FOR ATTENDANCE

PARENT'S AUTHORIZATION: This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give my permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child and in the event I cannot be reached in an emergency. I understand that basketball is a physical activity and a contact sport. Pocono Invitational has informed me that during this activity, there is a possibility of serious injury or death. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I also understand that we are responsible to have coverage with Blue Cross, Blue Shield or another commercial insurance carrier. I also waive

Pocono Invitational, Inc. of any responsibility to pay for hospital bills or insurance expenses.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

The camper and his/her parents agree to abide by the rules and regulations set up by the Camp for health, safety and welfare of the Camp. The following violations of camp rules will result in immediate dismissal from the camp without refund of camp fee:

- 1) Leaving campgrounds without permission.
- 2) Willful destruction of camp property.
- 3) Use of drugs and/or alcoholic beverages.
- 4) Fighting and/or continued insubordinate behavior resulting in disrupting of the camp program.

Camper's Signature \_\_\_\_\_ Date \_\_\_\_\_

If it is necessary, in the judgment of the camp, to use outside medical, surgical or dental aid for the camper's health, all such expenses shall be paid by the parent, unless covered by parent or guardian's insurance. The camp is not responsible for articles of clothing or personal belongings lost or damaged by theft, laundry or otherwise except if accepted by the camp director personally for safekeeping. If the parent cannot be reached in case of emergency, the camp is authorized to use its own judgment in any situation. The camp is given permission to use all pictures taken during my child's stay at camp for any advertising. The parent gives permission to Pocono Invitational for the son/daughter to travel in all licensed camp vehicles during the course of the regular camp session. This also includes buses that are used on rainy days to our other indoor facilities.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Check any positive answers:

- HEAD \_\_\_ Concussion \_\_\_ Severe or migraine headache \_\_\_ Dizziness \_\_\_ Nosebleeds
- SKIN \_\_\_ Severe acne \_\_\_ Boils \_\_\_ Recurring rashes
- EYES \_\_\_ Loss of vision \_\_\_ Double vision \_\_\_ Detached retina \_\_\_ Contact lens \_\_\_ Glasses
- NECK \_\_\_ Numbness of arms or legs \_\_\_ Stiff neck \_\_\_ Wry neck
- TEETH \_\_\_ Bridge work \_\_\_ Dental plates \_\_\_ Sever caries \_\_\_ Orthodontic appliances
- THROAT \_\_\_ Frequent sore throat \_\_\_ Tonicities
- EARS \_\_\_ Ruptured eardrum \_\_\_ Abscess \_\_\_ Draining ear \_\_\_ Hearing Loss
- CHEST \_\_\_ Deformity \_\_\_ Pain \_\_\_ Heart murmurs \_\_\_ Shortness of breath \_\_\_ Coughing up blood
- ABDOMEN \_\_\_ Cramps or pain \_\_\_ Vomiting \_\_\_ Rupture  
 \_\_\_ Bloody diarrhea \_\_\_ History of bloody urine \_\_\_ Sugar in the urine
- MALE \_\_\_ Genitourinary disorders \_\_\_ Removal of kidney \_\_\_ Undescended \_\_\_ Other
- FEMALE \_\_\_ Gynecological disorders \_\_\_ Removal of kidney \_\_\_ Ovarian cyst \_\_\_ Menstrual cycle
- SPINE \_\_\_ Scoliosis \_\_\_ Operations \_\_\_ Pain
- EXTREMITIES \_\_\_ History of varicose veins \_\_\_ Severe flat feet

Have you ever had: (circle yes or no)			Digestive Condition	yes	no
Pneumonia	yes	no	Diabetes	yes	no
Rheumatic Fever	yes	no	Kidney Disease	yes	no
Scarlet Fever	yes	no	High Blood Pressure	yes	no

List any other conditions no listed above: \_\_\_\_\_

History of Surgical Operations: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Athletic injuries previously sustained: \_\_\_\_\_

Do you require any special equipment to participate? \_\_\_\_\_

Doctor's comments: \_\_\_\_\_

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Signature of Examining Physician \_\_\_\_\_ Date \_\_\_\_\_