

Date  
Received:

**Chris Desso Basketball Camp  
Confidential Health History Form  
July 27- July 31, 2009**

**Part A: Participant Information**

Participant's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_

**Part B: Emergency Contact (If Parent is not available)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Part C: Health Insurance/ Health History**

Please list any medical conditions that might affect your daughter from participating in this program. Please include any medications currently taken by your child on a regular basis. If your child has a condition affecting their participation in the program, your physician must provide written authorization indicating approval of their participation.

Health Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Any Allergies or special needs/ concerns/ dietary restrictions, health concerns \_\_\_\_\_

Any medications (prescription and/ or non prescription including vitamins) currently taking –including dosage \_\_\_\_\_

**Part D: Release Statement**

I give permission for my child to be transported in a privately owned vehicle or emergency transportation for medical emergencies and/or for the release of medical records to an attending health care professional in case of injury or illness. I understand that every effort will be made to contact the parent/guardian. If one cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child. I certify that my child is in good health and has no limitations other than those listed above, which may predispose her to risk during the program. My signature confirms that I give my child permission to participate in the program and for the Athletic Director and Coach to have a copy of her Medical records.

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

**Part E: Media Release**

I give permission for the Peace of Christ Parish to make use of pictures of my daughter for informational/ advertising purposes on the POC website and bulletin.

Yes

No

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