ACCOUNTABILITY
ONE PLAYER SHARPENS ANOTHER
ANNUAL BASKETBALL CAMP

CLIENT HEALTH QUESTIONNAIRE

All information received on this form will be treated as strictly confidential. Please fill out completely and accurately. This information is essential to helping us develop a program that addresses your child's goals and interests and is safe and effective.

Medical Conditions

Please indicate any significant medical conditions, physical limitations, or any other concerns that might affect your child's/ward's full participation in **ACCOUNTABILITY ONE PLAYER SHARPENS ANOTHER CAMPS.**

__Asthma___Chronic Nosebleed___Diabetes___Digestive upsets___Ear, Nose, Throat infections ___Dislocated shoulder; swollen, painful joints; 'trick or lock' knee or other joint disability ___Fainting Spells ___Feet or Leg problems ___Hemophilia/Bleeding disorders ___Heart problems ___Hernia ___History of Head Injuries ___Migraine___Rash ___Recent illness or operation ___Rheumatic Fever ___Seizures ___Sleepwalking ___Urinary infections

**Other (specify)_____

Give details of usual treatment for each of the above conditions indicated:

_____

_____

Please explain if your child/ward has any medical condition that requires any modification of his/her program.

_____

_____

General

Yes____ No____ (1) Does your child/ward wear or carry medical alert identification (e.g., bracelet)?
If yes, please specify what is written on it:

_____

Yes____ No____ (2) Does your child/ward have any other relevant medical condition that will require modification of the program?
If yes, please explain:

_____

Allergies/Asthma

Please list all known confirmed allergies to the following:

(a) Foods:_____

If foods are life-threatening, please explain the symptoms and the treatment:

_____

(b) Medications:_____

(c) Other (e.g., bee or wasp stings, environmental allergies):

_____

Yes____ No____ Has your child/ward suffered any serious allergic or asthmatic reaction?

If yes, please provide details, including the type and severity of reaction:

_____

Is allergy considered: Mild____ Moderate____ Serious____ Life-Threatening ____

Yes____ No____ Has a doctor prescribed an Epi-Pen for your child/ward?

Yes____ No____ Has a doctor prescribed an inhaler for asthma? (Prescribed asthma inhalers must be carried by the child during training.) Yes____ No____ Has a doctor prescribed an inhaler for any other reason?

Dietary Restrictions

Please list any foods your child/ward should not eat for medical, dietary, or religious reasons:

_____

Medication

Does your child/ward take prescribed medication on a regular basis? Please specify:

_____

What prescribed medication(s) should your child/ward have with him/her during training?

_____

Should it become necessary for my child/ward to have medical care, I hereby give the coach permission to use her/his best judgment in obtaining the best of such service for my child/ward. I also understand that in the event of such illness or accident, I will be notified as soon as possible.

Athlete Name_____ Birth Date (dd/mm/yyyy)_____

Physician's Name Parent/Guardian Signature _____

Physician's Phone Date _____