

# SCREENING EXAM FOR ATHLETIC PARTICIPATION

**\*\* This exam must be conducted within one year prior to the start of the camp\*\***

NAME: \_\_\_\_\_  
DATE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
KNOWN ALLERGIES: \_\_\_\_\_  
DATE OF LAST TETANUS BOOSTER SHOT: \_\_\_\_\_  
CURRENT MEDICATIONS, OVER THE COUNTER DRUGS (INCLUDING VITAMINS), SUPPLEMENTS: \_\_\_\_\_

**MEDICAL HISTORY:** (please check any of the following that you have experienced at anytime in the past):

Ongoing or chronic illness     Surgery     Hospitalized overnight  
 Passed out or dizziness after exercise     Chest pain during exercise  
 Heart murmur     High blood pressure     Seizures     Asthma  
 Concussion or loss of consciousness  
 Cough, wheezing, or trouble after or during exercise  
 Racing of your heart or skipped heartbeats  
 Family member or relative who died of heart disease or sudden death before age 50  
 Problems with eyes (decreased vision, eyeglasses, contact lenses)  
 Orthopedic injuries (sprains, fractures, ligament damage). Please describe:  
\_\_\_\_\_

*I certify that the above information is complete and correct.*

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PHYSICAL EXAM:** BP \_\_\_\_\_ PULSE \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

*Please check if ABNORMAL and explain:*

Eyes/ears/nose/throat     Neck     Lymph nodes     Back     Heart  
 Shoulder/upper arm     Pulses     Elbow/forearm     Lungs     Wrist/forearm  
 Abdomen     Hip/upper leg     Genitalia/hernia     Knee     Skin  
 Lower leg/ankle/foot

EXPLANATION OF ABNORMALS: \_\_\_\_\_

**Cleared for all athletic activities**

**Not cleared for all athletic activities**

Reason: \_\_\_\_\_

Restrictions/Recommendations: \_\_\_\_\_

**Signature of Examiner:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Printed name of Examiner: \_\_\_\_\_

Address of Examiner: \_\_\_\_\_

# INSURANCE INFORMATION

*(parent/guardian please fill out)*

SUBSCRIBER: \_\_\_\_\_

RELATIONSHIP TO CAMPER: \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_

NAME OF INSURANCE  
COMPANY: \_\_\_\_\_

CLAIMS MAILING  
ADDRESS: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

**I hereby certify that the answers provided are true, complete, and correct to the best of my knowledge.**

\_\_\_\_\_ **Parent/Guardian Signature**

\_\_\_\_\_ **Date**

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## Parental Consent

I hereby grant permission for my son/daughter to attend the 2020 Coach Koz Fundamental Basketball Camp Inc. I also grant permission to the Coach Koz Fundamental Basketball Camp staff to act for me according to their best judgement in any emergency requiring medical attention and here-by waive and release the camp from any and all liability for any injuries incurred while at camp.

**Parent's/Gaurdian's Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_