

**Empower Basketball Academy, LLC  
Medical Record and Release Form**

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Parent's Names and Phone# \_\_\_\_\_  
Emergency Contact Name and Phone#: \_\_\_\_\_

**Allergies/Drug Reactions:**

Aspirin: Yes \_\_\_ No \_\_\_  
Penicillin: Yes \_\_\_ No \_\_\_  
Sulfa: Yes \_\_\_ No \_\_\_  
Bee Stings: Yes \_\_\_ No \_\_\_

\*If yes, does she carry an Epi Pen?: \_\_\_\_\_

**FOOD ALLERGIES: Please List**

\_\_\_\_\_  
\_\_\_\_\_  
Other: \_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Health History:**

Asthma: Yes \_\_\_ No \_\_\_      Diabetes: Yes \_\_\_ No \_\_\_  
Epilepsy: Yes \_\_\_ No \_\_\_      Heart Problems: Yes \_\_\_ No \_\_\_  
Head Injuries: Yes \_\_\_ No \_\_\_      Mono: Yes \_\_\_ No \_\_\_  
Orthopedic Injuries: (within the past 6 months): \_\_\_\_\_

*Please indicate Yes or No for over the counter medications that may be administered to your child if necessary due to injury and/or illness, according to the manufacturer's recommendations, by the Empower Basketball Academy Athletic Trainer.*

Ibuprofen: Yes \_\_\_ No \_\_\_    Tylenol: Yes \_\_\_ No \_\_\_    Sudafed: Yes \_\_\_ No \_\_\_    Antibiotic Ointment: Yes \_\_\_ No \_\_\_  
Hydrocortisone Cream 1%: Yes \_\_\_ No \_\_\_    Robitussin DM: Yes \_\_\_ No \_\_\_    Benadryl: Yes \_\_\_ No \_\_\_  
Pepto Bismol: Yes \_\_\_ No \_\_\_    Mylanta: Yes \_\_\_ No \_\_\_

**Health Insurance Information:**

***Please enclose a copy of both sides of your insurance card.***

Insurance Company Name: \_\_\_\_\_ Policy Holder Name & DOB \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insurance Company Address & Phone#: \_\_\_\_\_

**Physician Statement:**

***Participant CERTIFICATE OF IMMUNIZATIONS Must Be Attached***

*I certify that I have reviewed the medical history and status of the above person, and certify that she has no medical problems that restrict her from participation in vigorous physical activity while at the Empower Basketball Academy.*

Physician's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Release:**

I, the parent/guardian of \_\_\_\_\_ (the "Participant") give permission for the named Participant to receive emergency medical treatment deemed necessary by medical personnel if Participant is not able to act on her own behalf. I understand that there is a risk of injury to the Participant as a result of her participation in the program, and knowingly and voluntarily assume all risk of such injury. I hereby waive and release Empower Basketball Academy, LLC and staff from any liability for any injury or illness incurred while at the program. I will be financially responsible for any medical attention needed during the Program or resulting from an injury received at the Program. My medical insurance coverage shall be the insurance coverage for any medical treatment. By signing below, I have read and understand this release and I have voluntarily signed it. I agree this release is not only binding on me but will also be binding upon my personal representatives, executors, heirs, and assigns.

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

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