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 describe any medical conditions that might interfere with your full participation in the Academy (i.e. diabetes, asthma, etc.)

_____
_____

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:

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:_____

Please return to lhersey@smith.edu or Lynn Hersey, Basketball Office Ainsworth Gym, 102 Lower College Lane, Northampton, MA, 01063