

**2-4-1 SPORTS ACADEMY - EMERGENCY MEDICAL FORM AND RELEASE**

**This form must be completed each year even if a returning camper! Thank you!**

CHILD Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

In case of emergency, attempt to contact the following people :

	<u>Name</u>	<u>Relationship</u>	<u>Phone Number(s)</u>
1.	_____	_____	_____
2.	_____	_____	_____

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Please list **ALL** medical conditions which may ***in any way*** effect or limit the athlete’s ability to participate, or which responding medical personnel may need to know in the event of an emergency. (i.e. – asthma or other respiratory conditions, history of seizures, dizziness, fainting, heart problems, all previous injuries or surgeries, etc.) \_\_\_\_\_  
\_\_\_\_\_

Please list **ALL** medications being taken by the athlete, and the medical condition for which she/he takes them: \_\_\_\_\_  
\_\_\_\_\_

Please list **ALL** allergies, including medicines, foods, insects and other environmental causes, and the symptoms they cause: \_\_\_\_\_  
\_\_\_\_\_

Please list **ALL** medications which will be provided for use at camp (i.e.- inhaler, epi-pen, etc.): \_\_\_\_\_

**\*\* Please bring clear written instructions for the use of any medications, and give them to our First Aid Director on the first day of camp.**

Primary Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT AND USE OF PHOTOS/VIDEO**

I give my permission for **x** \_\_\_\_\_ to participate in The 2-4-1 Sports Academy at Denver South High School. I realize that athletic activities, such as those taking place at 2-4-1 Sports involve the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching and supervision, proper use of equipment, and strict observance of rules, injuries are still a possibility. On rare occasions, such injuries can be so severe as to result in total disability, paralysis, or even death. I also give permission for use of my child’s image at any/all 2-4-1 Sports Programs in photographs or video to be used for future promotional/marketing materials for 2-4-1 Sports. I hereby authorize you to take whatever action you deem necessary to provide for the health and welfare of my child, **x** \_\_\_\_\_, in case of an emergency.

**x** \_\_\_\_\_  
Parent or Guardian Name (Please Print)

**x** \_\_\_\_\_  
Parent’s or Guardian’s Signature

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

**Please return this form and a copy of a (school or camp) Physical from within the Past Three (3) Years that includes all immunizations to (sample for use on the next page): Send this form and physical to -**

Denver South High School  
Attn: Adam Kelsey  
1700 E. Louisiana Ave  
Denver, CO 80210

2-4-1 Denver South \_\_\_\_\_ Camper \_\_\_\_\_ Staff

**YOUTH CAMP HEALTH EXAM/RECORD  
FOR CAMPERS AND STAFF**

**Physical Exams Are Valid For 3 Years**

*(If you attended a 2-4-1 Sports Academy in the past 2 years, we may have a valid physical on file.)*

From Date of Last Examination

Camper

*Please Return Completed Form to the Camp*

Staff

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Guardian \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Week 1 camper

Week 2 camper

Both week camper

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:**

**Date of Exam** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ May participate in all camp activities

\_\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Is this individual taking prescription or over the counter medication(s)?  YES  NO If yes, indicate names of medication(s): \_\_\_\_\_

Does the individual have allergies?  YES  NO Explain: \_\_\_\_\_

Is the individual on a special diet?  YES  NO Explain: \_\_\_\_\_

Does the individual have special needs?  YES  NO Explain: \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

Measles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis B	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Mumps	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diphtheria	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Rubella	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pertussis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chickenpox	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pneumococcal conjugate	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tetanus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Polio	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, PA, APRN or RN

\_\_\_\_\_  
Date Form Signed

\_\_\_\_\_  
Telephone Number