

2014 Koubek Overnight Basketball Camp (August 17-21, 2014)

Medical Form

MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

Name _____ D.O.B. _____ Sex _____
Height _____ Weight _____ Blood Pressure _____ Pulse _____
Insurance Carrier _____ Policy # _____

Check any positive answers:

HEAD Concussion Severe or migraine headache Dizziness Nosebleeds
SKIN Severe acne Boils Recurring rashes
EYES Loss of vision Double vision Detached retina Contact lens Glasses
NECK Numbness of arms or legs Stiff neck Wry neck
TEETH Bridge work Dental plates Sever caries Orthodontic appliances
THROAT Frequent sore throat Tonicities
EARS Ruptured eardrum Abscess Draining ear Hearing Loss
CHEST Deformity Pain Heart murmurs Shortness of breath Coughing up blood
ABDOMEN Cramps or pain Vomiting Rupture
 Bloody diarrhea History of bloody urine Sugar in the urine
MALE Genitourinary disorders Removal of kidney Undescended Other
FEMALE Gynecological disorders Removal of kidney Ovarian cyst Menstrual cycle
SPINE Scoliosis Operations Pain
EXTREMITIES History of varicose veins Severe flat feet

Have you ever had: (circle yes or no)		Digestive Condition	yes	no
Pneumonia	yes no	Diabetes	yes	no
Rheumatic Fever	yes no	Kidney Disease	yes	no
Scarlet Fever	yes no	High Blood Pressure	yes	no

List any other conditions no listed above: _____

History of Surgical Operations: _____

Date of last tetanus shot: _____
Athletic injuries previously sustained: _____

Do you require any special equipment to participate? _____
Doctor's comments: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in basketball camp activities, except as noted above.

Signature of Examining Physician _____ Date _____