2019 Sports Clinics

Clinic Attending:

Clinic Name: _____

Clinic Date(s): _____

Clinic Head Coach: _____

PERSONAL INFORMATION & MEDICAL HISTORY

PLEASE RETURN TO CLINIC HEAD COACH BEFORE PARTICIPATION

Name _____ Birth Date _____ Age at Clinic _____
Last First Middle

Gender: ☐ Male ☐ Female

Parent/guardian _____ Home Ph. _____ Cell Ph. _____

Emergency contact (if other than parent or guardian):

Name/Relationship _____ Home Ph. _____ Cell Ph. _____

HEALTH HISTORY

The following information must be completed by the parent/guardian of the participant. The intent of this information is to provide clinic supervisors with health history background to provide appropriate care if needed. Any changes to this form should be provided, in writing, to the Clinic's Head Coach upon participant's arrival. Please provide complete, accurate information to ensure the clinic is aware of your child's needs.

GENERAL QUESTIONS: (Please explain all "**Yes**" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Been hospitalized within the last year ?	☐	☐
4. Had surgery within the last year?	☐	☐
5. Been restricted from activity within the last year?	☐	☐
6. Ever had a head injury/ concussion?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Ever passed out during or after exercise?	☐	☐
9. Ever passed out during or after exercise?	☐	☐
10. Ever had seizures?	☐	☐

	Yes	No
11. Have asthma and/or use an inhaler?	☐	☐
12. Have severe allergies/ require an Epi-Pen?	☐	☐
13. Have diabetes?	☐	☐
14. Ever had issues exercising in the heat (heat cramps, exhaustion, stroke)?	☐	☐
15. Have a current joint sprain ?	☐	☐
16. Have a current muscle strain?	☐	☐
17. Currently wear any protective braces/ taping?	☐	☐
18. Absence of a paired organ?	☐	☐
19. Seen for physical therapy in the last year?	☐	☐
20. Had problems with diarrhea/constipation?	☐	☐
21. Diagnosed with a learning/emotional disorder?	☐	☐

Please explain any yes answers, noting the number of the question:

_____

_____

ALLERGIES: List all known. (medications, food, other) Describe reaction and management of the reaction.

1. _____ _____
2. _____ _____
3. _____ _____

Is there any reason why this participant's activity at this clinic should be restricted in any way?

_____

_____

Department of Athletics & Physical Education, Box 750, Poughkeepsie, NY 12604
Phone 845-437-7450 **Fax** 845-437-7033
Website www.vassarathletics.com

MEDICATIONS BEING TAKEN
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely or for emergencies.

***NO Daily/routine medications will be administered by Clinic Staff ***

☐ **This person takes NO Medication on a routine basis.**

☐ **This person takes daily/routine medications as follows:**

Med #1 _____ Dosage _____ Reason for taking _____

Med #2 _____ Dosage _____ Reason for taking _____

☐ **This person has a current prescription for emergency medication (e.g., Epinephrine Pen-bee stings, Inhaler-asthma, etc.)**

Medication #1 _____ Reason for taking _____

Medication #2 _____ Reason for taking _____

IMPORTANT

The following signatures are required for participation in the Vassar College Sports Clinic(s)

Parent/Guardian Authorizations: This health history/ information for _____is correct and complete. The person herein described has permission to engage in all clinic activities except as noted. I have no knowledge of any physical or mental impairment that would affect my child's ability to participate fully unless noted. I hereby give permission to the clinic supervisors to provide routine healthcare, administer emergency medications listed, and seek emergency medical/dental treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the clinic representatives to arrange necessary related transportation for my child, in the event I cannot be reached in an emergency. I hereby give permission to the clinic supervisor(s) to secure and administer treatment, including hospitalization, for the person named above.

Indemnification: The undersigned parent/guardian of the registrant, for and in further consideration of the Vassar College Sports Clinic(s), accepting said registrant, hereby agrees to save and indemnify and keep harmless the said Vassar College Sports Clinic(s), its' agents and sponsors against any and all liability or responsibility fro personal or bodily injury (including death), and for any damage to or loss of property, however caused, that my child or I suffer as a result of or in connection with their participation in this clinic. I agree not to raise claims, judgments or demands arising as a result of any course of instruction or activity given the registrant by the Vassar College Sports Clinics.

Insurance Coverage: I attest that my child has medical insurance coverage in the state of New York, and they will either carry an insurance card with them or I will be immediately available to provide insurance information in the event my child is referred to a medical provider.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Date: _____

Questions or Concerns:

Michael Callahan, Sports Clinics Director
124 Raymond Ave.
PO Box 750, Poughkeepsie, NY 12604
Phone: 845-437-7471 Email: micallahan@vassar.edu