Northern Plains Visions of Sport Camp

Personal Health Inventory / Medical Form

Please print everything clearly. All information will remain confidential.

Date _____

Name _____

(Last) (First) (MI)

Address: _____

City_____State:_____Zip:_____

Home phone:_(_____)_____ Social Security #_____-_____-_____

Sex_____ Height_____ Weight_____ Birth date (MM/DD/YY)_____

Emergency Contact

Name:_____Relationship:_____

Address:_____

(Street) (City) (State) (Zip)

Home phone:_____ Work Phone:_____

Do you have health insurance? Yes _____ No _____

Name of health insurance company:

_____

Policy

number:_____

NOTE: BSU and NPVSC do not provide health/medical insurance for participants. You are responsible for health care costs incurred during the course of this camp.

We strongly recommend that participants join the United States Association of Blind Athletes (USABA). Membership forms are available through the USABA web site: USABA.org. Membership includes biannual newsletters, access to a data base of other athletes and sporting events, and secondary medical insurance. Cost is $20 per year per person.

The following is to be filled out by the participant's physician:

Description of visual impairment:

_____

Cause of blindness:_____

_____

Please list specific items after each question.

List all allergies (drugs, insects, foods)_____

_____

Do you have any dietary concerns (vegetarian, lactose intolerance, food allergies? Explain_____

_____

Please list current medications being taken, and schedules for use:

_____

_____

_____

Please put a check next to all conditions experienced within the last 5 years.

___ Hearing problems

___Dizzy spells, fainting, convulsions

___Motion sickness

___Chronic pain (arthritis, muscle or joint stiffness)

___Knee, shoulder, ankle or other joint problems

___Stomach, kidney, bladder, or other internal problems

___Other_____

___Broken bones, dislocations

___Chest pains or cardiac irregularities

___Shortness of breath, asthma

___High blood pressure

___Diabetes

___Neck or back problems

Do you have any other condition requiring the use of prescription drugs? If so, explain_____

_____

Other medical difficulties or health concerns?_____

_____

Have you been hospitalized in the last year? Explain_____

_____

The above information is accurate to the best of my knowledge:

_____

Signature of Physician Date

_____

Signature of participant or parent/guardian (if participant is under 18) Date

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BSU NPVSC CONSENT TO TREATMENT

In the event that I/my child should for any reason require any minor medical or surgical treatment and/or medication during the course of attendance in the camp in question, I authorize such physician or medical staff as the BSU/NPVSC staff appoints or designates to carry out the necessary treatment, or take me to the emergency room of the nearest hospital. I further authorize the hospital and its medical staff to provide treatment deemed necessary by them for my well-being.

_____

Participant signature or Date
Parent/guardian signature (if participant is under 18)