# BRIDGEMEN BASKETBALL CAMP MEDICAL FORM

Name ______________________ Date of Birth ______________________

Address ______________________________________________

Telephone Number ______________ Sex – Male or Female (circle one)

Name of Doctor ______________ Doctor's telephone No. ______________

Doctor's Address ______________________________________________

| VACCINE TYPE | Disease Mo/Day/ Yr | 1st Dose Mo/Day/ Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/Yr | 4th Dose Mo/Day/Yr | 5th Dose Mo/Day/Yr | Mo/Day |
|---|---|---|---|---|---|---|---|
| Diphtheria, Tetanus, Pertussis, (DTP) (If Td, DtaP, or DT, indicate in corner box) | XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX | | | | | | |
| Polio – Oral Polio Vaccine (OPV) (If Salk vaccine indicate in corner box) | XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX | | | | | | |
| Measles, Mumps, Rubella (MMR) | XXXXXXXX XXXXXXXX | | | | | | |
| Measles | XXXXXXXX XXXXXXXX | | | | Measles Serology | Date: | Titer: |
| Rubella | XXXXXXXX XXXXXXXX | | | | Rubella Serology | Date: | Titer: |
| Mumps | XXXXXXXX XXXXXXXX | | | | Mumps Serology | Date: | Titer: |
| Haemophilus B (HIB) | | | | | | | |
| Hepatitis B | | | | | | | |
| Others, Specify: | | | | | | | |

**Allergies to Medicine?** **Yes ___ No ___ If yes list type**

______________________________________________________________

**To Food?** **Yes ___ No ___ If yes list type**

______________________________________________________________

**Take Medications on a daily basis? Yes ___ No ___ If yes List type** ______________________________________________________________

**History of Medical Conditions (such as asthma)?**
**Yes ___ No ___ If yes list type** ______________________________

**History of Hospitalizations? Yes ___ No ___ If yes list type**

______________________________________________________________

**And Physical or Emotional Needs that we should be aware of?**
**Yes ___ No ___ If yes list type** ______________________________

______________________________________________________________

**Parent / Or Guardian Signature** ______________________________