

Campers Name _____

Part One:

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT THE CAMP OFFICE, AT TELEPHONE NUMBER (262) 945-4609, or email wiesema5@uwm.edu

CONSENT FOR MEDICATION ADMINISTRATION:

To the Parent(s) or Legal Guardian(s): If your son, daughter or ward will be under the age of 18 while at JBL Sports LLC, it is camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be administered by the Camp Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below.

- ☐ No medication has been brought to camp.
- ☐ I want the medication or medical devices self-administered (age 14 and above only).
- ☐ I want the medication or medical device administered by the Camp Sports Medicine Staff.
However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward (e.g., bee sting kits, inhalers).

Name of Medication(s): _____	Amount of Dosage to be Taken: _____
How is Medication Taken? _____	Time(s) of Day to be Taken: _____
Name of Prescribing Doctor: _____	Doctor's Phone Number: _____

Special Instructions: _____

_____ Signature of participant (if 18 or older)	_____ Date	_____ Signature of Parent or Guardian (if Participant is under 18 years old)	_____ Date
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CONSENT FOR MEDICAL TREATMENT:

To the Parent(s) or Legal Guardian(s): If your son, daughter or ward will be under 18 while at our camp, it is our policy to secure your consent for medical treatment. By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury. By signing below you are stating that you are aware of and accept the risk inherent in the program activity.

_____ Signature of participant (if 18 or older)	_____ Date	_____ Signature of Parent or Guardian (if Participant is under 18 years old)	_____ Date
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ASSUMPTION OF RISKS:

I understand that physical activity related to the Sport Camp, by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. Some of these involve strenuous exertions of strength using various muscle groups, some involve quick movement involving speed and change of direction, and others involve sustained physical activity, which places stress on the cardiovascular system. The specific risks vary from one activity to another, but in each activity the risks range from: 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as fractures, internal injuries, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death. I understand that the Camp has advised me to seek the advice of my physician before participating in this activity. I understand that I have been advised to have health and accident insurance in effect and that no such coverage is provided for my by Milwaukee Basketball Camps run by JBL Sports LLC. **I know, understand, and appreciate the risks that are inherent in the above-listed programs and activities. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.**

Signature of participant (if 18 or older)

Date

Signature of Parent or Guardian (if Participant is under 18 years old)

Date

HOLD HARMLESS, INDEMNITY AND RELEASE:

In consideration of permission for me to voluntarily participate in the Sport Camp, today and on all future dates, I, for myself, my heirs, personal representatives or assigns, agree to defend, hold harmless, indemnify and release the Milwaukee Basketball Camps run by JBL Sports LLC, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my participation in the above-listed program. This release includes claims based on the negligence of the Milwaukee Basketball Camps run by JBL Sports LLC, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence. **I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue.**

Signature of participant (if 18 or older)

Date

Signature of Parent or Guardian (if Participant is under 18 years old)

Date

SUMMER CAMP CONCUSSION/HEAD INJURY FORM:

I have been provided and read the concussion and head injury information sheet. I understand that there is a risk of injury during athletic participation and I agree to disclose any signs and symptoms of a concussion to the camp coaching staff. I also understand that I will be removed from play to eliminate the risk of further injury and will not be able to resume participation until evaluated and cleared by a health care provider who has experience with evaluating and managing pediatric concussions and head injuries. I will provide written clearance on the health care provider's letterhead or prescription note allowing me to continue participation in the activity.

Signature of participant (if 19 or older)

Date

Signature of Parent or Guardian (if Participant is under 19 years old)

Date

Part Two: SPORT CAMP HEALTH HISTORY QUESTIONNAIRE

Participant: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle Initial </div> Home Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Street City State Zip </div> Parent/Guardian: _____ Relationship: _____ Home Phone: _____ Work Phone: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Area Code + Number Area Code + Number </div> Address (if different from above): _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Street City State Zip </div> In case of an emergency or illness, if you are unable to be contacted, whom shall we notify: Name: _____ Relationship: _____ Address: _____ Phone: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Street City State Zip Area Code + Number </div> Name of Physician: _____ Phone: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Area Code + Number </div> Name of Insurance Co.: _____ Policy #: _____	<div style="display: flex; justify-content: space-between;"> Camp/Event: _____ <div style="text-align: right;">Camp Dates: _____</div> </div> <div style="text-align: right;">Date of Birth: _____</div> Height: _____ Weight: _____																		
	Does participant have allergic reactions to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 10%;">YES</th> <th style="text-align: left; width: 10%;">NO</th> <th style="text-align: left; width: 80%;">IDENTIFY</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Penicillin</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other Antibiotics _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other Medicines _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Insect Bites/Stings _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Foods _____</td> </tr> </tbody> </table>	YES	NO	IDENTIFY	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Other Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Medicines _____	<input type="checkbox"/>	<input type="checkbox"/>	Insect Bites/Stings _____	<input type="checkbox"/>	<input type="checkbox"/>	Foods _____
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	Is the participant taking any medication(s) regularly? <input type="checkbox"/> YES <input type="checkbox"/> NO																		

Has the participant ever had major surgery or been hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO Please explain any significant operations, accidents or illnesses, and last medical attention and the reason: <hr/> <hr/> <hr/> Does the participant have any physical conditions requiring special considerations? Explain. <hr/> <hr/> <hr/>	Has the participant ever suffered from, or are they currently experiencing, any of the following: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 10%;">YES</th> <th style="text-align: left; width: 10%;">NO</th> <th style="text-align: left; width: 80%;">YES NO</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Allergies</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Bleeding Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cancer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Colitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Epilepsy/Seizure Blackouts</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hernia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Joint Injury/ Surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Kidney Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Menstrual Difficulties</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental/Emotional Problem</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neck/Back Pain Injury</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ulcer</td> </tr> </tbody> </table> Other: _____	YES	NO	YES NO	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Joint Injury/ Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Problem	<input type="checkbox"/>	<input type="checkbox"/>	Neck/Back Pain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
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