

# Official Health Certificate

San Antonio Spurs/Silver Stars Basketball Camps  
One SBC Center  
SAN ANTONIO, TX 78219  
ATTN: Dave Walsh

This form has been approved by the American Medical Association and the National federation of State High School Athlete Associations. Please have your family physician fill it out. When completed, mail to the address above before camp is to begin.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Camp Attending \_\_\_\_\_

Significant Past Illness or Injury \_\_\_\_\_

\_\_\_\_\_

Eyes \_\_\_\_\_ R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Ears \_\_\_\_\_ Hearing R \_\_\_\_\_ L \_\_\_\_\_

Respiratory \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Liver \_\_\_\_\_ Spleen \_\_\_\_\_  
Hernia \_\_\_\_\_

Muscular Skeletal \_\_\_\_\_  
Skin \_\_\_\_\_

Neurological \_\_\_\_\_  
Genitalia \_\_\_\_\_

Comments or suggestions concerning the child's health or treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify on this date I have examined this child and find him physically able to compete in the supervised activities of the San Antonio Spurs/Silver Stars basketball camps.

Physicians Signature \_\_\_\_\_ Examination Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_

**PARENTS OR GUARDIANS PERMISSION**

I hereby give my consent for the above child to participate in the supervised basketball instructional program of the San Antonio Spurs/Silver Stars Basketball Camp, and agree not to hold the Camp liable for any injury illness sustained by the child during any session at the Camp.

In the event that I cannot be reached in an emergency I hereby give permission to the physician selected by the Camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Signature of Parent or Guardian\_\_\_\_\_

Date\_\_\_\_\_

Home Phone\_\_\_\_\_ Business  
Phone\_\_\_\_\_

If not available in an Emergency notify:

Name\_\_\_\_\_

Address\_\_\_\_\_

Home Phone\_\_\_\_\_ Business  
Phone\_\_\_\_\_

This side is to be filled in by parent and checked with physician at time of examination.

Child's Name\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_

Phone\_\_\_\_\_

**HEALTH HISTORY: (CHECK GIVING APPROXIMATE DATES)**

Allergies: Diseases:

Ear Infections\_\_\_\_\_ Hay Fever\_\_\_\_\_ Chicken  
Pox\_\_\_\_\_

Rheumatic Fever\_\_\_\_\_ Ivy Poisoning\_\_\_\_\_

Measles\_\_\_\_\_

Convulsions\_\_\_\_\_ Insect Stings\_\_\_\_\_ German  
Measles\_\_\_\_\_

Diabetes\_\_\_\_\_ Penicillin\_\_\_\_\_

Mumps\_\_\_\_\_

Epilepsy\_\_\_\_\_ Drugs\_\_\_\_\_

Asthma\_\_\_\_\_

Appendicitis\_\_\_\_\_ Other\_\_\_\_\_

Tuberculosis\_\_\_\_\_

Heart or Kidney Trouble: \_\_\_\_\_  
Other \_\_\_\_\_

Operations or Serious  
injuries \_\_\_\_\_

Chronic or Recurring  
Illness \_\_\_\_\_

**IMMUNIZATION HISTORY**

Dates of Basic Immunizations or Most Recent Booster Dates:

DPT Series \_\_\_\_\_ Booster \_\_\_\_\_ Tetanus  
Booster \_\_\_\_\_

Polio DPV \_\_\_\_\_ Booster \_\_\_\_\_  
Typhoid \_\_\_\_\_

Measles Vaccine \_\_\_\_\_ Mumps  
Vaccine \_\_\_\_\_

German Measles (Rubella) \_\_\_\_\_

Small Pox \_\_\_\_\_  
Other \_\_\_\_\_

Medicine Needed or  
Used \_\_\_\_\_

Purpose \_\_\_\_\_ Kind \_\_\_\_\_  
Dosage \_\_\_\_\_

Is it presently being given? \_\_\_\_\_

Serious Conditions to be watched for such as allergy (to drugs or insect bites, etc.)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_