

Official Health Certificate

San Antonio Spurs/Silver Stars Basketball Camp
One AT&T Center
SAN ANTONIO, Texas 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 basketball camp.

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.)?

