Thorn Wrestling Camps, LLC
ThornCamps@gmail.com
Phone: 763-913-7759

(Pages 1-3 To Be Completed by Parent/Guardian)

2018 Health Form Page 1 of 4

Please complete and MAIL IN BEFORE START OF SESSION. PLEASE PRINT.

Attendee Name:_____Birthday (mm/dd/yyyy): _____

***Information must be completed by Parent/Guardian of Minors for all parts of form.**

EMERGENCY CONTACT: *

If parent/guardian is not available in an emergency, notify:

Name:_____

Relationship:_____

Cell:_____

AUTHORIZATION (REQUIRES SIGNATURE):*

IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE: The attendee listed above ("Camper") has my permission to engage in all Thorn Wrestling Camp (the "Camp") activities and programs whether those take place on or off Camp property except as noted on this form and under all terms of the Application Form and Emergency Medical Release & Liability Waiver that I have already received. I agree that Camper is voluntarily participating with the knowledge of the inherent and other risks (both known and unknown) in these activities and programs. My Camper and I accept full responsibility for any injury, damage, death or other loss resulting from these risks and/or resulting from my Camper's own negligence or other misconduct. A Certificate of Health is required by the State of Minnesota based on a physical examination within 90 days of Camp and noting any limitation for participation at Camp (see Medical Form).

AUTHORIZATION FOR TREATMENT: I hereby give permission to the Camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the Camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the person named above. This completed form may be photocopied. This Camp has permission to obtain copies of my child's treatment and health record from any provider who treats my child. I understand that information about my child's health will be shared on a "need to know" basis with Camp staff. I will notify the Camp in writing of any health related changes between the date of this form and my Camper's arrival at Camp.

This Camp health form is complete to the best of my knowledge and contains no misrepresentations or omissions that might or would affect my child's experience at Camp.

***Signature of Parent/Guardian: _____ Date:_____**

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IMMUNIZATION HISTORY:*
Provide the month and year for each immunization or attach a copy of your child's clinic/school immunization record. Starred (★) immunizations must be current.

Immunization	Date: Month(s) & Year(s)	Immunization	Date: Month(s) & Year(s)
Tetanus Booster ★ (within 10 years)		Varicella (chicken pox)	
MMR (Measles, Mumps, Rebella) ★		Haemophilus influenze	
Polio Series ★		Hepatitis B	
Pertussis Booster		Hepatitis A	

MEDICATIONS:*
"Medication" is any substance a person takes to maintain and/or improve his or her health and includes vitamins and homeopathic remedies - if required for medical reasons.

☐ This Camper will not take any daily medications while attending Thorn Wrestling Camp.

☐ This Camper will take the following medication(s) while attending Thorn Wrestling Camp. Bring enough of each med to last the **ENTIRE** session.

Note: All medications must arrive in the original, appropriately labeled pharmacy containers.

Name of Medication	Reasons for Taking It	Dose Given & When	Date Started?
		☐ Breakfast Dose: _____ ☐ Lunch Dose: _____ ☐ Evening Dose: _____ ☐ Bedtime Dose: _____	
		☐ Breakfast Dose: _____ ☐ Lunch Dose: _____ ☐ Evening Dose: _____ ☐ Bedtime Dose: _____	
		☐ Breakfast Dose: _____ ☐ Lunch Dose: _____ ☐ Evening Dose: _____ ☐ Bedtime Dose: _____	

BILLING INFORMATION FOR HEALTH CARE:*
Parent/guardians are financially responsible for health care given by an out-of-camp provider for medication, illness, treatment, pre-existing conditions, etc.

PLEASE PRINT Medical insurance information and **provide a copy of an insurance card**. Copy both sides so addresses and telephone numbers are readable.

Campers Name:_____

Insurance Company: _____

Claims Address: _____

Policy number for your child: _____

If applicable, RxBIN: _____ RxPCN: _____

PREFERRED HEALTH-CARE PROVIDERS:

Name of Camper's primary doctor(s):_____Phone:_____

Name of dentist(s):_____Phone:_____

Name of orthodontist(s) _____Phone:_____

IMPORTANT: Please notify the Camp if this Camper is exposed to any communicable diseases prior to Camp attendance.

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GENERAL HEALTH HISTORY: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

YES	NO		YES	NO	
☐	☐	Operations or serious injuries (list dates & condition below)	☐	☐	Allergies to foods (explain below)
☐	☐	Disability or other special needs	☐	☐	Allergies to any medications (explain below)
☐	☐	Special Equipment (e.g. ear plugs, braces, retainers)	☐	☐	Any other allergies (explain below)
☐	☐	Any special dietary needs (list below)	☐	☐	Any chronic recurring conditions (i.e. seizures, ear infections, etc.)
☐	☐	Vegetarian (eats no meat)	☐	☐	Allergies to foods (explain below)
☐	☐	Piercings/tattoos (list below)	☐	☐	Asthma
☐	☐	Wear glasses, contacts, or protective eyewear	☐	☐	Diabetes
☐	☐	Have any skin problems	☐	☐	Frequent headaches
☐	☐	Any conditions or restrictions that affect participation in the program (explain below)			

Please explain "Yes" answers in the space below or on a separate sheet.

MENTAL, EMOTIONAL AND SOCIAL HEALTH HISTORY: Check "Yes" or "No" for each statement.

1. This Camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD ..... ☐ Yes ☐ No
2. This Camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder, eating disorder ..... ☐ Yes ☐ No
3. This Camper has an emotional health concern (specify _____) ..... ☐ Yes ☐ No
4. During the past academic year, this Camper has seen or is currently seeing a professional to address mental/emotional concerns ..... ☐ Yes ☐ No

   If "yes," was the answer to any of the four statements above, attach a statement from your Camper's professional (e.g., psychiatrist, physician) that addresses the following three things:
   (a) Describes the concern and the Camper's management plan (including medication) while in our program;
   (b) Describes the behaviors that will indicate to our staff the your Camper's needs professional referral; and
   (c) Provides recommendation for the Camper's participation in our program.
5. This Camper has had a significant life event that continues to affect the Camper's life ..... ☐ Yes ☐ No

   If "yes," please attach written information about the event - death of a loved one, family change, adoption, new sibling, survived a disaster—its impact upon your Camper's life, and care tips for the Camp staff.

WHAT HAVE WE FORGOTTEN TO ASK? Please provide in the space below any additional information about the Camper's health that you think important or that may affect the Camper's ability to fully participate in the Camp program. Attach additional information if needed.

IMPORTANT: Please notify the Camp if this Camper is exposed to any communicable diseases prior to Camp attendance.

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2018 Thorn Camp Skin Infection Prevention

Our goal at Thorn Camps is to keep your wrestler safe and healthy, and to secure everyone with as much mat time as possible. With this goal in mind we are adding a new skin safety measure.

With so many of our campers attending multiple camps and tournaments throughout the summer, we need to be extra vigilant towards skin infections. One such infection, HSV-1, is a cold sore virus that 80%+ of the adult population has and is very prevalent in wrestling due to the skin on skin contact. HSV-1 is a spreadable, communicable disease and is highly contagious. If a wrestler has a breakout during camp he won't be able to continue wrestling and will be sent home.

We are requesting that all campers that have been treated for HSV- 1 virus in the past come to camp on a preventative dose of Valtrex or generic equivalent. We ask that for 5 days prior to camp and through the duration of camp your child be on the preventative medicine.