



(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 influenzae	
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?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Evening Dose: _____ <input type="checkbox"/> Bedtime Dose: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Evening Dose: _____ <input type="checkbox"/> Bedtime Dose: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Evening Dose: _____ <input type="checkbox"/> 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.

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.**

## 2018 Health Form Page 3 of 4

**GENERAL HEALTH HISTORY:** Check “Yes” or “No” for each statement. Explain “Yes” answers below.

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

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.

Camper Name: \_\_\_\_\_ Session: \_\_\_\_\_

### 2018 CAMPER HEALTH RECORD (For Camp Use Only) Page 4 of 4

<b>Screening:</b>  _____ Date  _____ Time
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SCREENING has been conducted according to Camp protocol and any significant findings noted.

- A. Any signs/symptoms of illness or injury upon arrival? .....  No  Yes as noted below
- B. History of exposure to communicable disease? .....  No  Yes as noted below
- C. Additions or corrections to information on this health history? .....  No  Yes as noted below
- D. Medication given to healthcare staff? .....  No  Yes as noted below

Screening Completed by: \_\_\_\_\_

NOTES:

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**EXIT NOTE** - Check one of the following:

- Left Camp this day with no reported illness or injury symptoms
- Left Camp this day with the following problem/concern: \_\_\_\_\_  
\_\_\_\_\_

Date: _____ Initials: _____
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This person was told about the problem and instructed about follow-up as noted above: \_\_\_\_\_



(To Be Completed by Licensed Health Care Professional)  
**2018 Medical Form**

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

<p><b>Parents:</b>          Have your health care provider complete this form as information from your medical provider gives our program a better understanding of your child's health need(s).</p> <p><b>To Health Care Professionals:</b>          This child has enrolled in our summer wrestling camp. The program includes physical activity. Our staff will use your information to help meet needs of the person described.</p>	Name of Camper: _____ Date of Birth: ____/____/____ Session Dates: _____
	PLEASE PRINT
	MD/NP Name: _____ Office Phone: (____) _____ - _____ City/State/Zip: _____ Date this form was completed: _____

Please Check the Applicable Boxes Below:

N/A     This child is under the care of a physician for the following reason(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

N/A     Describe the treatment(s) to be continued at the camp for this child: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

N/A     List prescription medication(s) that this person should take while at camp (provide medical order for administration): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

N/A     This person is allergic to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

N/A     Should exposure occur, how should the allergic reaction be treated? If this an anaphylactic response, will this child bring an epinephrine device? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

N/A     Describe significant physical findings regarding this camper and/or describe any limitations which may impact the child's participation in our program: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments on a separate sheet.

**Licensed Medical Professional Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## **2018 Thorn Camp Skin Infection Prevention**

**The following does NOT apply if your camper is 12 years of age or younger.**

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 13 years of age and older 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. *If you are unable or unwilling to follow this preventative approach, you will be required to sign a waiver (see page 7) indicating your refusal to participate.*



## Additional Liability Waiver – Refusal to Participate in Prevention Measures

Wrestler's Name \_\_\_\_\_

Camp Attending \_\_\_\_\_

For good and valuable consideration, including the opportunity to participate in Thorn Wrestling Camps, LLC for the period indicated above, the parent(s) and/or legal guardian(s) of the minor wrestler named above agree, in addition to other releases and waivers previously provided:

1. I/WE hereby agree and acknowledge that Thorn Wrestling Camps, LLC has requested that our child participate in preventative measures to lessen the risk of contracting HSV-1 (Herpes Symplex Virus), and I/WE have declined to have our child participate in such preventative measures.
2. I/WE certify that our minor child have not contracted HSV- from 1 (Herpes Symplex Virus) or any other skin conditions which would limit our child's participation in the camp program.
3. I/WE agree and acknowledge that it is policy of Thorn Wrestling Camps, LLC that any wrestler with a suspected spreadable skin condition will be suspended from participation in the camp program or until such condition is sufficiently healed and he is cleared to resume practice by a health care provider. I/WE agree and acknowledge that if our child contracts HSV-1 (Herpes Symplex Virus) or any other skin condition during the camp program, our child may be sent home.
4. I/WE agree and acknowledge that we will be entitled to NO REFUND of any camp program fees if our child is sent home or excluded from the camp program due to a skin condition.
5. I/WE HEREBY RELEASE, WAIVE, HOLD HARMLESS, DISCHARGE AND COVENANT NOT TO SUE Thorn Wrestling Camps, LLC and its staff, owners, managers, employees and agents (referred to as "Releasees") from any and all claims, claims for refunds of fees paid, causes of actions, demands, losses, damages or liability arising from my minor child's participation in Thorn Wrestling Camps, LLC, including any claim, cause of action, or liability arising out of negligence, and any claims related to being excluded from camp programs or being sent home Thorn Wresling Camps, LLC program due to a skin condition. I/WE agree that this Additional Liability Waiver applies to any injury or damage to the property of my minor child while participating in Thorn Wrestling Camps, LLC or while in, on or upon the premises where the camp is being conducted. I/WE further covenant not to sue the Releasees for any alleged claims, causes of action, or liability released hereunder. Nothing in this Release and Waiver should be construed as releasing, discharging, or waiving any claims I/WE may have for gross negligence or reckless, willful, wanton or intentional acts on the part of the Releasees.

This Additional Liability Waiver shall be in addition to any other liability waivers executed by the undersigned in favor of Thorn Wrestling Camps, LLC, and shall not supplant, supersede or other wise effect such other liability waivers.

THIS DOCUMENT RELIEVES THORN WRESTLING CAMPS, LLC AND ITS OWNERS, EMPLOYEES OR AGENTS FROM ANY LIABILITY FOR PERSONAL INJURY, WRONGFUL DEATH, PROPERTY DAMAGE, AND ECONOMIC LOSSES CAUSED BY NEGLIGENCE AND OTHER CAUSES. I/WE HAVE READ THIS RELEASE AND WAIVER OF LIABILITY AND HAVE SIGNED IT VOLUNTARILY AND FREELY, UNDERSTANDING THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND INTENDING MY/OUR SIGNATURE(S) TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Participant Signature \_\_\_\_\_

