Athlete's Name: _____

2020 Medical/Athlete Information Form

Ability First Sports Camp 2020! It is **CRUCIAL** that this form be filled out with as much detail and accuracy as possible. By doing so, we are able to hire and place the appropriate staff with each athlete, and allow the nursing staff to provide accurate daily medical needs and to place your athlete in the correct level of sports/programs. Our #1 goal at Ability First is safety! Please take your time filling this form out and think about all the information that would be beneficial to us.

Thank you for taking the time to fill out this form. Respectfully, The Ability First Staff

1- Returning Camper: ☐ Yes ☐ No If yes how many years? _____

2- Athlete's Name:_____
Gender: M F Age: _____ Date of Birth: _____
Disability:_____
_____

3- Parent/Guardian
Name(s):_____
Address:_____
City:_____ State:_____ Zip:_____
Home#:_____ Cell#(s):_____
Work#(s):_____ Fax#:_____
Email:_____

4- Emergency Contact: #1
Name:_____ Relationship to Athlete:_____
Home#:_____ Cell#_____
Address:_____
City:_____ State:_____ Zip:_____

Emergency Contact: #2
Name:_____ Relationship to Athlete:_____
Home#:_____ Cell#_____
Address:_____
City:_____ State:_____ Zip:_____

5- What are the symptoms of the athlete's primary disability?
_____
_____

6- Secondary disability(s)? ☐ Yes ☐ No If yes explain:
_____
_____

7- Any Mental Retardation? (circle correct level) **MILD - MODERATE - SEVERE and/or**
☐ OTHER (examples; ADD, ADHD, LD, Autism, etc…)_____
Explain symptoms:_____
_____

8- Any Psychological concerns?
☐ Depression ☐ Anxiety ☐ Panic Attacks ☐ OCD ☐ Other_____
Explain symptoms:_____
_____

9- Any language barriers we need to be aware of? ☐ Yes ☐ No
If yes explain:_____

10- Any vision problems? ☐ Yes ☐ No Glasses or contacts (circle one if it applies)
If yes explain diagnosis & limitations if any:_____

11- Can the athlete follow multi-step instructions? ☐ Yes ☐ No

12- History of seizures? ☐ Yes ☐ No Date of last seizure:_____/_____/_____
Type(s):_____
Frequency:_____

Does athlete have warning before seizure (aura)? ☐ Yes ☐ No
Symptoms:_____
Physical/mental symptoms before a seizure:_____
_____
Physical/mental symptoms & length of recovery after a seizure:_____
_____

13- Describe any past illnesses and/or surgeries that apply to your athlete's disability:
Date: _____/_____/_____
_____
Date: _____/_____/_____
_____
Date: _____/_____/_____
_____

14- Athletes assistive devices, if any: ☐ manual wheelchair ☐ power wheelchair ☐crutches
☐ walker` ☐ AFOs ☐ glasses ☐ brace (limb, torso, etc.) ☐ Other _____

15- Bringing any adaptive sports equipment? ☐ rugby chair ☐ track chair ☐ tennis chair
☐ hand bike ☐ Other_____

16- Can the athlete bear weight? ☐ Yes ☐ No

17- Transferring and balance…
Chair/walker to bed? ☐ Yes ☐ No ☐ Partial assist ☐ Full assist
Floor to chair/walker/bed? ☐ Yes ☐ No ☐ Partial assist ☐ Full assist
Chair/walker to toilet? ☐ Yes ☐ No ☐ Partial assist ☐ Full assist

Can sit up straight without assistance (on couch, dinning room chair, etc.)? ☐ Yes ☐ No
Pickup fallen objects? ☐ Yes ☐ No

18- Can athlete feed themselves? ☐ Yes ☐ No Can athlete eat with utensils? ☐ Yes ☐ No
Can athlete drink from a cup? ☐ Yes ☐ No Can athlete drink with a straw? ☐ Yes ☐ No

19- Can athlete get from one point to another in a timely manner? ☐ Yes ☐ No

20- Can athlete manage uneven surfaces? ☐ Yes ☐ No

21- Does athlete fatigue/get tired easily or can they keep up a good energy level during a long day of activity?

_____

22- Sports and leisure interest:

_____

_____

_____

23- Circle the Activities of Daily Living (ADL's) that the athlete can do INDEPENDENTLY. ***change clothes – bladder care – bowel care – brush teeth – bathe – shoes on & off – make bed- pickup/clean room – brush hair – pick out clothes – wash hands – personal hygiene –put shirt on or off – pull pants on or off – feed self- sort laundry***

24- Does athlete have a bowel/bladder program? ☐ Yes ☐ No
If yes, explain in detail: _____

_____

_____

25- Any additional hygienic needs beyond bowel and bladder care? ☐ Yes ☐ No
If yes, explain in detail:_____

_____

_____

26- Any allergies to medication, food, environment and/or bee stings…? ☐ Yes ☐ No
What allergen & reaction: _____

_____

_____

27- Special instructions and any other important information we should know: _____

Medication Name	Dosage	Frequency

_____

_____

28- Athlete's medical insurance:

Company name:_____

Insurance carrier: _____

Member ID #:_____**Group #:**_____

Primary Physician: _____**Phone #:**_____

Medicare? ☐ **Part A** ☐ **Part B** ☐ **Part D** **SSN#**_____-_____- _____

***Please attach a photocopy of athlete's current medical card(s)!**

Medical Wavier

I, _____ give permission for my minor (for whom I have guardianship) _____, to participate in Ability First Youth Sports Camp (Ability First).

(minor's name)

Should it be necessary for the participant to seek emergency care, I hereby give Ability First employees permission to use their judgment on the need for medical services. I authorize any emergency personnel/physicians or hospital staff to perform emergency treatment to the participant. I understand that all medical costs are the responsibility of participant's insurance, guardian, or participant themselves. Ability First is not responsible for any medical cost.

_____

Signature of parent/guardian Date

Contact info:

camp@abilityfirstsports.org--Ability First Sports P.O. Box 4235 Chico, CA 95927 --Ability First- 530-588-0335