

# COASTAL CAROLINA SOCCER ACADEMY

## Medical History, Treatment Permission and Release

Note: This form is required prior to participation in summer sport camps. Participation will not be permitted until this form has been completed and signed and is on file with the sports camp. **Please print using black ink.**

Camp Name \_\_\_\_\_ Session \_\_\_\_\_

### Participant Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

First

Middle

Last

Home Address \_\_\_\_\_

Street Address

City

State

Zip Code

Father/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Other/Emergency Contact Person Name \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID Number \_\_\_\_\_

Medical History (Please use back of this sheet if necessary) Date of last tetanus booster \_\_\_\_\_

Is the participant under the care of a provider for a medical and/or psychological problem? No Yes

If yes, please explain: \_\_\_\_\_

Is the participant taking medication prescribed by a health care provider? No Yes

If yes, please explain: \_\_\_\_\_

**Allergies!** If yes please list the allergy and provide additional information, if necessary.

Insect bites/stings: No Yes \_\_\_\_\_

Food: No Yes \_\_\_\_\_

Medications: No Yes \_\_\_\_\_

Other: No Yes \_\_\_\_\_

**RELEASE OF LIABILITY:** I hereby release and discharge, indemnify and hold harmless the Regents of Coastal Carolina University, and their member officers, agents, employees and any other persons or entities acting on their behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against all claims, demands, costs and expenses, and causes of action whatsoever, either in law or equity, arising out of or in any way connected with any property loss and/or bodily injury and/or disability, arising from my child's participation in the sports camp activities, including overnight stays on campus, if applicable.

**CONSENT FOR TREATMENT:** I hereby give my permission to a camp certified athletic trainer to supervise on-site first aid for minor injuries. In the event of injury such as broken limb, sprain, contusion, laceration, concussion, etc., or illness requiring medical diagnosis or treatment, I hereby give my consent for sports camp staff to secure the proper medical care for my son/daughter including transportation and hospitalization, if necessary. Every attempt will be made to contact the parent/guardian to inform you of the need for any medical attention beyond minor first aid, if necessary.

**PHYSICAL EXAMINATION WITHIN ONE YEAR:** I certify that within the past 12 months my child has had a physical examination by a physician and that she/he is physically able to participate in the sports camp activities.

**ASSUMPTION OF FINANCIAL RESPONSIBILITY:** I hereby acknowledge that I am responsible for medical charges incurred during sports camp participation. I further understand that the sports camp carries an excess medical insurance policy for sports injuries to the camper that may result from camp activities. Camp insurance has limits and exclusions and any secondary charges not covered under this plan will be my responsibility. This policy may only be utilized after my primary insurance company has processed the claims and issued an explanation of benefits. **IMPORTANT: My signature below indicates that I have read and understand these terms.**

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Relationship to Participant \_\_\_\_\_