

CAMPBELL UNIVERSITY SPORTS CAMP MEDICAL INFORMATION

This form must be completed and returned in order to participate in the sports camp

Name of Camp _____ Male _____ Female _____ Dates of Camp _____

Participant's Name _____ Soc. Sec. # _____ Date of Birth _____

Address _____

Home Phone _____ Email Address _____

Mother's Name _____

Mother's Day Phone _____ Mother's Evening Phone _____ Mobile _____

Father's Name _____

Father's Day Phone _____ Father's Evening Phone _____ Mobile _____

Emergency Contact's Name _____ Relationship _____ Phone _____

Insurance Coverage:

Company _____ Group _____

Policy Number _____ Phone Number of Insurance Company _____

Policy Holder and Social Security # _____

If there is a known history, please circle:

Allergy to bee stings/bug bites

Asthma

Epilepsy/Seizures

Dizziness/Fainting

Diabetes/Hypoglycemia

High Blood Pressure

Other: _____

Please list any additional allergies or other health-related problems: _____

Date of Most Recent Tetanus Immunizations? _____

Allowed medication – circle all that apply to your child:

Pseudofedrin	Yes	No	Tylenol	Yes	No
Advil/Ibuprofen	Yes	No	Pepto Bismal	Yes	No
Maalox/Antacid	Yes	No	Benadryl 25 mg	Yes	No

Note: Only medications listed on this form may be taken by the minor while at camp unless prescribed by the university's infirmary physician. All medications should be brought in the original prescription bottle and will only be administered as directed on bottle unless accompanied by a doctor's note. All medications are to be dispensed through the university's infirmary by the nurses on staff.

My child is on the following prescription or over the counter medication (list medication and dosage) _____

I certify that within the past year, the aforementioned participant has had a physical examination by a licensed physician, and that he/she is physically able to participate in the sports camp/clinic activities.

In the event of an injury, illness, and/or accident involving my son/daughter, I hereby give my consent for medical treatment(s) at Campbell University Student Health Services. Also, I hereby give my consent to a certified athletic trainer and/or his/her designee to render and supervise on-site first aid treatments, to the appropriate camp/clinic personnel to properly transport my son/daughter to an appropriate medical facility for care, and to a licensed physician to hospitalize and secure proper treatment(s), including injections, diagnostic procedures, anesthesia, surgery, and/or other reasonable and necessary procedures for my son/daughter. I hereby authorize my health insurance company to pay for benefits for the cost of such treatment(s). I also authorize the disclosure of medical information to my insurance company for the purpose of any claim.

PARENT/LEGAL GUARDIAN'S SIGNATURE: _____

DATE: _____