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| Sport: |  | | | | | | | | Camp Name: | | |  | | | | | | | Camp Date(s): | | | | | | |  | | | |
| Participant Name: | | | |  | | | | | | | | | | | Date of Birth: | | | | |  | | | | | | Male / Female  (please circle) | | | |
| Home Address: | | |  | | | | | | | | | | | |  | |  | | | |  | |  | | | | |  |  |
|  | | | (Street) | | | | | | | | | | | | | | (City) | | | | | | (State) | | | | | | (Zip) |
| Parent/Guardian Name: | | | | | | |  | | | | | | | | Parent/Guardian Phone No: | | | | | | | | | |  | | | | |
| Emergency Contact: | | | | |  | | | | | | | | | | Emergency Phone No: | | | | | | |  | | | | | | | |
| Relationship to Participant: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pre-Existing Conditions (Please circle if the participant is known to have):** | | | | | | | | | | | **Allowed Medications - to be dispensed only by Campbell University Health Center (please circle all that apply to the participant):** | | | | | | | | | | | | | | | | | | |
| Asthma | | | | | | Epilepsy/  Seizures | | | | | Sudafed | | Yes No | | | | | Advil  (Ibuprofen) | | | | | | | | | Yes No | | |
| Diabetes | | | | | | High Blood Pressure | | | | | Tylenol | | Yes No | | | | | Pepto Bismol | | | | | | | | | Yes No | | |
| Sickle Cell | | | | | | Dizziness/  Fainting | | | | | Maalox/  Antacid | | Yes No | | | | | Benadryl (25mg) | | | | | | | | | Yes No | | |
| Hypoglycemia | | | | | |  | | | | |
| Other Conditions or allowed medications (please specify): | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Allergies:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of last tetanus immunization: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Additional health-related problems (list and explain in detail): | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| **Medication regularly taken by the participant (please list all medications and dosages):** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
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| ***\*\*PLEASE NOTE:*** Only medications listed on this form may be possessed and taken by the minor while at camp unless prescribed by a university health center provider. All prescription medications must be brought **in the original bottle** and will only be administered as directed on the bottle unless accompanied by a doctor’s note.***\*\**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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By signing this document, I certify that within the past year the aforementioned participant has had a physical examination by a physician, or other licensed medical provider, and that he/she is physically able to participate in the sports camp/clinic activities.

Additionally, by signing this document, 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 Health Center. 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) for my son or daughter, including injections, diagnostic procedures, anesthesia, surgery, and/or other reasonable and necessary procedures. I hereby authorize my health insurance company to pay for benefits and 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.

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| Parent/Legal Guardian’s Signature: |  | Date: |  |

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| **Insurance Information** | | | | | | | | | | | |
| Policy Holder: | |  | | | | Date of Birth: |  | | Last 4 of SSN: | |  |
| Company: |  | | Policy No: | |  | | | Group No: | |  | |
| Insurance Company Phone Number: | | | |  | | | | | |