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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): |  |
|  |
| **Medication regularly taken by the participant (please list all medications and dosages):**  |  |
|  |
|  |
| ***\*\*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.

|  |  |  |  |
| --- | --- | --- | --- |
| 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:  |  |