

## Campbell University Athletic Camp Medical Information

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

Sport: \_\_\_\_\_ Camp Name: \_\_\_\_\_ Camp Date(s): \_\_\_\_\_ Male / Female  
 Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (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. \*\*

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: \_\_\_\_\_

**Insurance Information**

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_  
 Company: \_\_\_\_\_ Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_  
 Insurance Company Phone Number: \_\_\_\_\_

