Campbell University
Athletics Camp Medical Information

All sections of this form MUST be completed in order to participate in the sports camp

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	Heart problem				
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: _____