University of South Carolina Aiken – Sports Camps Medical Form

This form must be completed and signed by the camper's parent or legal guardian**. THIS FORM WILL BE RETURNED IF IT IS NOT COMPLETE. PLEASE PRINT CLEARLY!**

CAMPER INFORMATION

Camper's Name_____ Last 4 digits of Social Security# _____
Permanent Address_____ Date of Birth _____
City, State, Zip _____ Home Phone # _____

MEDICAL EMERGENCY CONTACT INFORMATION

PERSON TO CONTACT FIRST: NAME_____
RELATION TO CAMPER_____
DAYTIME PHONE #_____EVENING PHONE #_____
BACKUP CONTACT: NAME_____
RELATION TO CAMPER_____
DAYTIME PHONE #_____EVENING PHONE #_____

INSURANCE POLICY INFORMATION

THE ABOVE-NAMED CHILD IS COVERED BY HEALTH INSURANCE: (Circle One) YES - NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:
POLICY HOLDER'S (PH) NAME_____ P.H. DATE OF BIRTH_____
ADDRESS_____
RELATION TO CAMPER_____
CITY, STATE, ZIP_____
OCCUPATION_____
PH'S EMPLOYER_____ INSURANCE COMPANY_____
INSURANCE COMPANY'SADDRESS_____
POLICY #_____
PLAN_____

PERMISSION TO TREAT & MEDICAL RELEASE

Check ONE of the following and sign below:

_____ In the event of illness or injury, I understand that every attempt will be made to contact me before medical action is taken. However, in the event of an emergency, I hereby grant my consent for medical treatments and permission for the attending physician or appropriate medical personnel, to hospitalize, secure proper treatment and/or injections, anesthesia, or surgery. I will be responsible for any medical or other charges connected with my child's attendance at the camp.

_____I DO NOT want any type of medical treatment provided to my child.

_____ _____ _____
Parent/ Guardian Name Parent/ Guardian Signature Date

DIRECTIONS: TO BE COMPLETED BY LEGAL GUARDIAN. PLEASE ANSWER ALL QUESTIONS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE PRINT CLEARLY AND ATTACH ANY SPECIFIC RECOMMENDATION FROM YOUR PHYSICIAN TO THIS FORM.

DOES THE CAMPER HAVE ANY OF THE FOLLOWING? (IF YES, PLEASE DESCRIBE)

DRUG ALLERGIES? NO YES_____ FOOD ALLERGIES? NO YES_____
ALLERGIES TO INSECTS? NO YES_____SPECIAL DIETARY NEEDS? NO YES_____
ASTHMA? NO YES_____ FREQUENT HEADACHES? NO YES_____
DIZZINESS OR SEIZURES? NO YES_____
LIST: OTHER HEALTHPROBLEMS_____

IS THE CAMPER CURRENTLY TAKING MEDICATION? NO YES- IF YES,
WHAT?:_____

PLEASE NOTE: Our staff cannot administer any medications, prescription or otherwise, to campers. This includes over-the-counter medications like Advil or Tylenol for
minor headaches or pains. If the camper will need to take medication while attending our camp, he must bring the medication to camp and assume responsibility for taking it as needed.

WILL YOUR SON/ DAUGHTER REQUIRE ANY SPECIFIC TREATMENT FOR A MEDICAL/ EMOTIONAL CONDITION WHILE PARTICIPATING IN OUR CAMP? NO YES
IF YES, PLEASE
DESCRIBE:_____

MEDICAL HISTORY

IMMUNIZATION DATES: MEASLES_____ MUMPS_____ RUBELLA_____
MMR(COMBINED)_____ LAST TETANUS_____ POLIO SERIES_____
DATE OF LAST CHECK_UP_____
REASONS FOR ANY HOSPITALIZATION IN THE PAST 5 YRS? NO YES_IF YES,
EXPLAIN_____
_____

PHYSICIAN'S INFORMATION

PHYSICIAN'S NAME_____
ADDRESS_____
CITY, STATE, ZIP_____
PHONE#_____