

# CAMP MEDICAL FORM/PARENTAL CONSENT WAIVER

This form must be completed and signed by the camper's parent or legal guardian. Please print clearly.

SPORT CAMP/CLINIC: \_\_\_\_\_ SPORT CAMP/CLINIC DATES: \_\_\_\_\_

## CAMPER INFORMATION

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
ADDRESS: \_\_\_\_\_ AGE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_ GRADE: \_\_\_\_\_  
HOME PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ GENDER:  M  F  
EMAIL ADDRESS: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

MOTHER'S NAME: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_  
WORK NUMBER: (\_\_\_\_) \_\_\_\_\_ WORK NUMBER: (\_\_\_\_) \_\_\_\_\_  
CELL PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ CELL PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_  
BACKUP EMERGENCY CONTACT: \_\_\_\_\_ PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_  
RELATION TO CAMPER: \_\_\_\_\_

## MEDICAL HISTORY INFORMATION

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

1. KNOWN DRUG ALLERGIES?  No  Yes \_\_\_\_\_
2. FOOD ALLERGIES?  No  Yes \_\_\_\_\_
3. ALLERGIES TO INSECTS?  No  Yes \_\_\_\_\_
4. ASTHMA?  No  Yes \_\_\_\_\_
5. ARE THERE ANY MEDICAL CONDITIONS WE SHOULD BE AWARE OF?  No  Yes \_\_\_\_\_
6. IS THE CAMPER CURRENTLY TAKING ANY MEDICATIONS?  No  Yes \_\_\_\_\_

IF YES, PLEASE LIST ALL MEDICATIONS AND SPECIFY ANY THAT NEED TO BE TAKEN DURING CAMP. \_\_\_\_\_

## INSURANCE POLICY INFORMATION

IS THE CAMPER CURRENTLY COVERED BY HEALTH INSURANCE?  Yes  No

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

HEALTH INSURANCE PROVIDER: \_\_\_\_\_

NAME OF POLICYHOLDER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

