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#_________________________