



University of San Diego

SPORTS CAMPS MEDICAL/ INSURANCE INFORMATION

This form is required for participation in University of San Diego Sports Camps

CONTACT/ CAMPER INFORMATION

<u>CAMPER'S LAST NAME:</u>	<u>CAMPER'S FIRST NAME:</u>	<u>CAMPER'S GENDER:</u> MALE FEMALE	<u>CAMPER'S DATE OF BIRTH:</u>	<u>CAMPER'S AGE:</u>
<u>PARENT/ GUARDIAN:</u>			<u>PARENT/ GUARDIAN PHONE NUMBER(S):</u> CELL:	
<u>ADDRESS:</u>			WORK:	
			HOME:	
<u>ALTERNATE EMERGENCY CONTACT:</u>			<u>ALTERNATE EMERGENCY CONTACT NUMBER:</u>	
IS THE CAMPER INSURED? YES NO		<u>NAME OF MEDICAL PLAN:</u>		<u>PHONE NO.:</u>
TYPE OF MEDICAL PLAN: HMO PPO POS OTHER		<u>SUBSCRIBER'S NAME:</u>		<u>POLICY/ GROUP NO.:</u>
<u>NAME OF LOCAL PHYSICIAN:</u>			<u>TELEPHONE OF LOCAL PHYSICIAN:</u>	

CAMP ENROLLMENT INFORMATION

<u>CAMP #1:</u>	<u>DATE(S):</u>
<u>CAMP #2:</u>	<u>DATE(S):</u>
<u>CAMP #3:</u>	<u>DATE(S):</u>

HEALTH HISTORY INFORMATION

IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW: PLEASE EXPLAIN IN DETAIL

1. IS THE CAMPER CURRENTLY UNDER A DOCTOR'S CARE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. HAS THE CAMPER RECENTLY HAD SURGERY OR BEEN HOSPITALIZED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. DOES THE CAMPER CURRENTLY HAVE ANY MEDICAL CONDITIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. IS THE CAMPER CURRENTLY TAKING ANY MEDICATION(S)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. DOES THE CAMPER HAVE ANY DIETARY RESTRICTIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. DOES THE CAMPER HAVE ANY ALLERGIES?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. DOES THE CAMPER HAVE ASTHMA?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. CAMPER'S OTHER CONDITION(S) THAT MAY AFFECT PARTICIPATION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

NON-PRESCRIPTION MEDICATION

INDICATE THE OVER-THE-COUNTER MEDICATIONS (GENERIC FORMS) YOU AUTHORIZE THE STAFF TO ADMINISTER AS NEEDED

TYLENOL <input type="checkbox"/> YES <input type="checkbox"/> NO	COUGH DROPS <input type="checkbox"/> YES <input type="checkbox"/> NO	PEPTO-BISMOL <input type="checkbox"/> YES <input type="checkbox"/> NO
IBUPROFEN <input type="checkbox"/> YES <input type="checkbox"/> NO	BENADRYL <input type="checkbox"/> YES <input type="checkbox"/> NO	SUDAFED <input type="checkbox"/> YES <input type="checkbox"/> NO

AUTHORIZATION FOR TREATMENT

THE INFORMATION PROVIDED IS CORRECT, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES AS NOTED. I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE UNIVERSITY OF SAN DIEGO TO EVALUATE ANY INJURIES/ ILLNESSES, ADMINISTER FIRST-AID AND MAKE REFERRALS FOR FURTHER CARE AS DEEMED NECESSARY. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GRANT PERMISSION TO THE USD MEDICAL STAFF AND PROVIDERS TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION FOR THE ABOVE SPECIFIED PERSON. I FURTHER UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY MEDICAL COSTS INCURRED OR NOT COVERED BY INSURANCE

PARENT/GUARDIAN OR ADULT CAMPER SIGNATURE: _____ **DATE:** _____