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

CAMPER'S LAST NAME:	CAMPER'S FIRST NAME:	CAMPER'S GENDER: MALE FEMALE	CAMPER'S DATE OF BIRTH:	CAMPER'S AGE:

PARENT/ GUARDIAN:	PARENT/ GUARDIAN PHONE NUMBER(S):
	CELL:
ADDRESS:	WORK:
	HOME:
	ALTERNATE EMERGENCY CONTACT NUMBER:
ALTERNATE EMERGENCY CONTACT:	

IS THE CAMPER INSURED? YES NO	NAME OF MEDICAL PLAN:	PHONE NO.:
TYPE OF MEDICAL PLAN: HMO PPO POS OTHER	SUBSCRIBER'S NAME:	POLICY/ GROUP NO.:
NAME OF LOCAL PHYSICIAN:	TELEPHONE OF LOCAL PHYSICIAN:	

CAMP ENROLLMENT INFORMATION

CAMP #1:	DATE(S):
CAMP #2:	DATE(S):
CAMP #3:	DATE(S):

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?	☐ YES	☐ NO
2. HAS THE CAMPER RECENTLY HAD SURGERY OR BEEN HOSPITALIZED?	☐ YES	☐ NO
3. DOES THE CAMPER CURRENTLY HAVE ANY MEDICAL CONDITIONS?	☐ YES	☐ NO
4. IS THE CAMPER CURRENTLY TAKING ANY MEDICATION(S)?	☐ YES	☐ NO
5. DOES THE CAMPER HAVE ANY DIETARY RESTRICTIONS?	☐ YES	☐ NO
6. DOES THE CAMPER HAVE ANY ALLERGIES?	☐ YES	☐ NO
7. DOES THE CAMPER HAVE ASTHMA?	☐ YES	☐ NO
8. CAMPER'S OTHER CONDITION(S) THAT MAY AFFECT PARTICIPATION?	☐ YES	☐ NO

NON-PRESCRIPTION MEDICATION

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

TYLENOL	☐ YES	☐ NO	COUGH DROPS	☐ YES	☐ NO	PEPTO-BISMOL	☐ YES	☐ NO
IBUPROFEN	☐ YES	☐ NO	BENADRYL	☐ YES	☐ NO	SUDAFED	☐ YES	☐ 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 GIV PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE UNIVERSITY OF SAN DIEGO TO EVALUATE ANY INJURIES/ ILLNESSES, ADMINISTER FIRST-AI 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 FURTHE UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY MEDICAL COSTS INCURRED OR NOT COVERED BY INSURANCE

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