

University of South Carolina – Sports Camps – Emergency Contact/Medical Consent 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 _____ 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'S ADDRESS _____
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 HEALTH PROBLEMS _____
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 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# _____