Parents/Guardians must complete and sign this form in order to finalize a camper's registration and allow participation in camp activities. A doctor's physical exam is not necessary—only general medical information is required.
Hay Fever or Allergies

Allergy to Medicines (including penicillin, tetanus)

Impaired Sight or Hearing, Chronic Ear Infections

Recent Surgical Operations, Accidents or Injuries

Any Infectious Disease

Skin Disease

History of Skin problems (decubitus ulcers)

Diabetes

Currently taking Medicines (list names and doses)

Medication that needs refrigeration

Under on-going care of Physician (NAME/PHONE #) for chronic/recurring problem

Do You Wear Glasses? YES [ ] NO [ ] SOMETIMES [ ]

Do You Wear Contact Lenses? YES [ ] NO [ ]

Date of last TETANUS BOOSTER

**Food Allergies (Please List):**

**INSURANCE INFORMATION:**

FAMILY DOCTOR'S NAME: ___________________ CLINIC/HOSPITAL NAME: ___________________

CITY/STATE: ___________________ PHONE: (____) ___________________

HEALTH INSURANCE PROVIDER: Name

Address City State / Zip Code

NAME OF POLICY HOLDER: ___________________ DATE OF BIRTH: _____ / _____ / _____

POLICY NUMBER: ___________________

- As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be sought. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for medical treatment, as recommended by an attending physician.
- I approve the release of medical information to the University of Illinois Sports Medicine Staff and any treating physician.
- I approve the release of insurance information to the health care provider (doctor, hospital of my child).
- I approve the health care provider to release information to the insurance company.
- I approve benefits from my insurance are payable to the health care provider.
- I also understand the $1,000 maximum accident coverage in effect while at the University of Illinois campus does not cover pre-existing conditions, self-inflicted injuries, or illnesses. Medical treatment must be rendered and claims must be submitted within 45 days of the conclusion of the camp.
- If the benefits are paid directly to me, I will pay the health care provider.
- I verify the above information is correct to the best of my knowledge.
- My signature verifies the above information to be correct to the best of my knowledge.

SIGNATURE: ___________________ DATE: ____________

(Parent or Guardian)

CAMPER'S SIGNATURE: ___________________ DATE: ____________

(If over 18 years old)

Parents/Guardians must complete and sign this form in order to finalize a campers registration and allow participation in camp activities.

A doctor’s physical exam is not necessary—only general medical information is required.