UNIVERSITY OF ILLINOIS at URBANA-CHAMPAIGN
EMERGENCY MEDICAL INFORMATION

(*Summer Sport Camp Fax Number – 217-244-0014)

(Please list the CAMP NAME / CAMP DATES for each session in which the camper is currently registered)

CAMP NAME: _____**CAMP DATES:** _____

CAMP NAME: _____**CAMP DATES:** _____

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*CAMPER INFORMATION:

NAME: _____

DISABILITY: _____

ADDRESS: _____
Number / Street City State / Zip Code

AGE: _____ GENDER: _____ DATE OF BIRTH: _____/_____/_____

*PARENT/GUARDIAN/OTHER:

NAME: _____
Relationship

HOME PHONE: (_____) _____WORK/CELL PHONE: (_____) _____

ADDRESS: _____
Number / Street City State / Zip Code

*EMERGENCY CONTACT:

NAME: _____
Relationship

HOME PHONE: (_____) _____WORK/CELL PHONE: (_____) _____

ADDRESS: _____
Number / Street City State / Zip Code

*HEALTH INFORMATION STATEMENT:

Check below any information you feel the staff may need to maximize the safety and the well being of the attendee. To the right of the condition statement is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate important information. This information is confidential.

[ ] Neurological Disorders (epilepsy, emotional stress, convulsion)_____
_____
[ ] Lung Disease (asthma, persistent cough, tuberculosis) _____
_____
[ ] Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure_____
_____
[ ] Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever) _____
_____
[ ] Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)
_____
[ ] Arthritis, Kidney or Bladder Disease_____

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

(OVER) →

[ ] 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):_____
****we will e-mail you a Dining Allergy Form to be completed prior to your arrival at camp****
***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)

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(OVER) →