Revised 11/12/09

UNIVERSITY OF ILLINOIS at URBANA-CHAMPAIGN
EMERGENCY MEDICAL INFORMATION

(*Summer Sport Camp Fax Number – 217-265-8122)

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

SPORT: ________________________ **CAMP NAME:** __________________________ **CAMP DATES:** _______________

SPORT: ________________________ **CAMP NAME:** __________________________ **CAMP DATES:** _______________

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*CAMPER INFORMATION:

NAME: ____

SCHOOL NAME: ____

ADDRESS: ____
Number / Street City State / Zip Code

AGE: ___________ GENDER: ________ DATE OF BIRTH: ______/______/______

*PARENT/GUARDIAN/OTHER:

NAME: ____
Relationship

HOME PHONE: (_____) _________________________ WORK PHONE: (_____) __________________________

ADDRESS: ____
Number / Street City State / Zip Code

*EMERGENCY CONTACT:

NAME: ____
Relationship

HOME PHONE: (_____) _________________________ WORK 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.

[ ] Nervous or Mental (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______________________________
[ ] Allergy to Foods______________________________
[ ] 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______________________________
[ ] Significant Orthopedic and/or Neuromuscular Impairment (e.g. loss of limb, spinal cord injury)
____

*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

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