

**John Daly Soccer Camp 2014**  
**Session I – July 13-16 \_\_\_\_\_**  
**Session II - July 20-23 \_\_\_\_\_**  
**John Daly, Camp Director**

**Camper Information Form**  
Athletic Training Services

**This form must be complete and on file with the camp before your child can participate in any camp activity. Make sure it is received or brought to check-in so that the staff can review it at that time.**

Camp: \_\_\_\_\_ Dates: \_\_\_\_\_

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_  
(please print) last first M.I.

Address \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent's Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Mother's Work phone \_\_\_\_\_ Father's Work phone \_\_\_\_\_

**In an emergency, if parents cannot be contacted, notify:**

Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Alternate number (explain) \_\_\_\_\_

***\*If you are going to be on vacation or otherwise away from the above numbers while your child is in camp, please make a note to that effect and give alternate phone numbers.***

**HEALTH HISTORY**

Operations, serious illnesses, injuries--give dates and outcomes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_  
Drug Allergies/sensitivities \_\_\_\_\_  
Heat illness/Exhaustion \_\_\_\_\_  
Asthma \_\_\_\_\_  
Date of last Tetanus-Diphtheria Booster \_\_\_\_\_  
List any special diet required and why \_\_\_\_\_  
List any current medications and reason \_\_\_\_\_  
\_\_\_\_\_

## INSURANCE INFORMATION

While participating in summer sports camps your son or daughter is at an increased risk of injury. By completing this form you are aware of these risks and understand that **you take financial responsibility for necessary medical expenses** that may be incurred from an injury sustained while your child is at camp.

In most cases--but not all--providers will be willing to process insurance claims for you. Some health care providers will bill you directly for services rendered, thus you will need to pay any bills from them and seek reimbursement from your insurance. Please make sure to fill out the following information completely so that we can give it to providers up-front:

Complete name of insurance company: \_\_\_\_\_

Address where claim is to be mailed to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Policy Holder's name: \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Policy Holder's Subscriber ID# \_\_\_\_\_ Policy Holder's group #(or name) \_\_\_\_\_

Policy Holder's address \_\_\_\_\_

\_\_\_\_\_  
Policy Holder's DOB: \_\_\_\_\_

### AUTHORIZATIONS--PLEASE READ CAREFULLY

\* I certify that the above camper has had an official medical examination within the past year and is physically fit and able to participate in the rigors of this summer sports camp.

\* I hereby grant permission for my child to be medically treated for injuries or illnesses during his or her stay at camp.

\* I authorize payment of medical benefits to all providers for all services and materials they provide during the care of an injury/illness.

\* I understand that I am financially responsible for charges for services rendered for the care of an athletic injury, and/or sickness/illness.

\* A photostatic copy of this authorization shall be deemed as effective and valid as the original.

\* I grant permission for the camp athletic trainers to administer the following indicated over-the-counter medications to my child. These may only be used for the signs and symptoms indicated below and only for a 24-hour period. After this time, a physician will be consulted and the camp athletic trainer will call me.

*(Please Initial beside each medication for permission)*

\_\_\_\_\_ Tylenol — for minor head aches (not thought to be associated with dehydration or head injury) and for fever less than 101<sup>0</sup>F.

\_\_\_\_\_ Pepto Bismol — for upset stomach, stomachache and diarrhea.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_