Green Bay Women's Soccer Youth Camps

Camper's Name: _____

HEALTH INFORMATION RELEASE FORM

BOTH pages of this form **MUST** be brought with the camper to check-in.

This form must be completed and signed by the participant's legal guardian (unless over 18). The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session.
(You will not be admitted to camp without this form, completed and signed).

PLEASE BRING THIS FORM WITH YOU TO CAMP

PARTICIPANT INFORMATION:

Participant's Name_____ Date of Birth___/___/____
Permanent Address_____
City/State/Zip:_____ Phone_____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:
Name_____
Relation _____
Daytime Phone_____
Evening Phone_____

Backup contact (relative or friend):
Name_____
Relation_____
Daytime Phone_____
Evening Phone_____

INSURANCE POLICY INFORMATION (As much as possible):

The above named child is covered by health insurance: YES NO
If yes, please provide the following information which is required to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name: _____
Address _____ P.H.'s Date of Birth___/___/____
City/State/Zip_____ Relation_____
Occupation_____
P.H.'s Employer_____
Employer's Address_____
Insurance Company_____
Insurance Company's Address_____
Policy #_____ Plan #_____

PHYSICIAN'S INFORMATION, Please **PRINT** the following information:

Physician's Name: _____
Address:_____
City/State/Zip:_____
Telephone:_____

MEDICAL TREATMENT CONSENT:

I, authorize the Green Bay Women's Soccer Youth Camps, LLC Soccer Camps staff to give permission for the named camper to receive emergency medical treatment as they see necessary. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

_____ _____ _____

Legal Guardian's Signature (Participant if over 18) | Print Name | Date

Camper's Name: _____

Directions: Completion of this form by a parent or guardian (unless over 18) is required before a student can participate. Attach any specific recommendations from your physician to this form.

CAMPER'S HEALTH STATUS: HAS THE CAMPER EVER HAD (If yes, please describe)

No Yes Allergies (Food): If yes, list _____
No Yes Asthma: _____
No Yes Bleeding Disorder: _____
No Yes Depression: _____
No Yes Diabetes: _____
No Yes Emotional Disorder: _____
No Yes Fainting/Dizzy Spells: _____
No Yes Heart Condition: _____
No Yes Medication Allergies: If yes, list _____
No Yes Seizure disorder: _____
No Yes Frequent Headaches: _____
No Yes Allergies to insect stings: _____

Other health problems:_____
Limitations of Activities: _____
Medications the camper is currently taking:_____

Will your daughter/son require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. Yes No

_____

MEDICAL HISTORY (If available)

IMMUNIZATION DATES:

Mumps: _____
Measles: _____
Rubella: _____
Tetanus Toxoid: _____
Polio Vaccine: _____
Tuberculin Test: _____