

2018 Rutgers Field Hockey Camp

This form must be completed and signed by the participant's parent or legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session.

ATHLETE INFORMATION

Camper's Name _____
Permanent Address _____ Date of Birth _____ Sex _____
City, State, Zip _____ Home Phone _____
Camper's Email _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First:	Backup Contact (relative or friend)
Name _____	Name _____
Relation to Camper _____	Relation to Camper _____
Daytime Phone(____) _____	Daytime Phone (____) _____
Evening Phone(____) _____	Evening Phone (____) _____

Guardian's Email _____

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No
If yes, provide the following information, required by the Medical Center to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name _____	P.H.'s Date of Birth: _____
Address _____	Relation to Camper: _____
City, State, Zip _____	Occupation: _____

P.H.'s Employer _____
Employer's Address _____
Insurance Company _____
Insurance Company's Address _____
Insurance Company's City, State, Zip _____
Policy _____ Plan _____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize Rutgers Field Hockey Staff to seek medical treatment for the athlete as they see necessary at the Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment or hospital care, and that it is given to provide the 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 for all the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the 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 staff will notify me or my designee as soon as possible of all diagnoses and treatments.

Legal Guardian's Signature _____

Print Name _____

