2019 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:

Name_____

Relation to Camper_____

Daytime Phone(____)_____

Evening Phone(_____)_____

Backup Contact (relative or friend)

Name_____

Relation to Camper _____

Daytime 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

_____

Date_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM!

DOES THE CAMPER CURRENTLY HAVE ANY OF THE FOLLOWING? (If yes, please describe):

Drug Allergies:	No	Yes_____
Food Allergies:	No	Yes_____
Allergies to Insect Bites:	No	Yes_____
Special Dietary Needs:	No	Yes_____
Asthma:	No	Yes_____
Frequent Headaches?	No	Yes_____
Dizziness or Seizures?	No	Yes_____

LIST

OTHER HEALTH PROBLEMS:

MEDICATIONS THE CAMPER IS CURRENTLY TAKING: None

Please note: Our staff cannot administer any medications, prescription or non-prescription, to athletes. This includes over the counter medicines like Advil or Tylenol for minor headaches and pains. If the athlete will need to take medications while attending our program, she must bring the medication to the facility and assume responsibility for taking it as needed or indicated.

Will your child require any specific treatment for a medical/emotional condition while participating in our program? No Yes

If yes, please describe:

_____

_____

MEDICAL HISTORY

IMMUNIZATION DATES:	Date of last medical check-up:_____
Measles:	Reasons for any hospitalizations in the past 5 years:
Mumps:	Explain:
Rubella:	
OR	
MMR (combined):	
Last Tetanus:	
Polio Series:	

PHYSICIAN'S INFORMATION

Physician's Name_____

Address_____

City, State, Zip_____

Telephone (_____) _____