

Training Camp Confidential Health Information Form
Emergency and Health Insurance Information / Authorization
(PLEASE TYPE OR PRINT IN BLACK INK!)

Sex Male Female Date of Birth (mm/dd/yyyy) _____ Age _____ Height _____ Weight _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Country: USA _____ Home Phone # _____

FATHER EMERGENCY CONTACT INFORMATION	MOTHER EMERGENCY CONTACT INFORMATION
Name _____	Name _____
Address _____	Address _____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell _____	Cell _____
Beeper _____	Beeper _____
Email address _____	Email address _____

EMERGENCY CONTACT INFORMATION
Name _____
Address _____
Home Phone _____ Work Phone _____ Cell _____
Relation to child: <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Friend <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____

PRIMARY INSURANCE INFORMATION (A clear copy of both sides of card may be included)
The child I am sending to camp is covered by this policy? <input type="checkbox"/> no <input type="checkbox"/> yes
Primary Insurance Company _____
Address _____
Phone # _____
Employee/Policy Holder _____ Insured ID _____
Plan # _____ Policy # _____
Employee relation to child: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____
Type of Insurance- <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity(deductible) <input type="checkbox"/> Other (describe) _____
Child must be seen first by (HMO) _____ Phone _____

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HEALTH HISTORY (Please elaborate, using other side if necessary)		
1. Child has these known allergies, allergic reactions, etc... <input type="checkbox"/> None		
Bee sting <input type="checkbox"/> no <input type="checkbox"/> yes; Penicillin <input type="checkbox"/> no <input type="checkbox"/> yes; Other medications or food <input type="checkbox"/> no <input type="checkbox"/> yes _____		
Specify treatment _____		
2. Child has a history of Asthma <input type="checkbox"/> no <input type="checkbox"/> yes; Epilepsy <input type="checkbox"/> no <input type="checkbox"/> yes; Diabetes <input type="checkbox"/> no <input type="checkbox"/> yes; Other conditions _____		
Specific treatment _____		
3. Child is currently on these medications: <input type="checkbox"/> None		
Name _____	Dosage _____	Purpose _____
Name _____	Dosage _____	Purpose _____
Name _____	Dosage _____	Purpose _____
4. Child has these physical activity restrictions: <input type="checkbox"/> None		

5. Child has these dietary restrictions: <input type="checkbox"/> None		

6. Date of child's last physical or medical check-up: _____		
7. Date of child's last tetanus immunization: _____		
8. Has the child recently been exposed to any communicable disease? <input type="checkbox"/> no <input type="checkbox"/> yes _____		
9. Any other information, physical, mental or emotional which might prove helpful to Camp Director, Counselors, Nurse or Physician:		

10. Family Doctor: _____		
City _____	State _____	Office Phone _____

Training Camp, Inc. has adopted the following procedures for caring for your son / daughter in the event that he/she becomes sick or injured while attending the camp: **1)** A representative from the camp will call the home telephone number listed. If there is no answer, **2)** A representative will call the Father's/Mother's home, cellular, work and beeper phone numbers as listed. If there is no answer, **3)** A representative will call the emergency contact phone numbers and the physician listed. **4)** If none of the above answer, a representative will call an ambulance, if necessary, to transport your son/daughter to an appropriate medical facility. **5)** Camp representatives will continue to call all listed numbers until one is reached. A message may also be left on an answering machine. **6)** Based upon the medical judgment of the attending physician, your son/ daughter may be admitted to a local medical facility.

In the event of an injury, illness, and/or accident involving my son / daughter, I hereby give my consent for medical treatment and permission to camp staff to supply and/or supervise on-site first aid, to the appropriate camp personnel to properly transport my son / daughter to an appropriate medical facility for care, and to a licensed physician, chosen by the Camp Director, to hospitalize and secure proper treatment (including injections, diagnostic procedures, anesthesia, surgery, and/or other reasonable and necessary procedures) for my son / daughter. I agree to assume any and all costs related to such treatment. I hereby authorize my health insurance company to pay benefits for the costs of such treatment. I also authorize the disclosure of medical information to my insurance company for the purpose of any claim. I understand that each participant must provide his/her own medical insurance in order to participate in the camp.

I understand that I am responsible for any and all medical and/or other charges related to the aforementioned participant's attendance and participation in Training Camp. I also understand that registration is not considered complete until this completed and signed form is on file.

I hereby give permission for _____ to attend Training Camp.

 Parent / Guardian Signature

 Date