SANTA CLARA UNIVERSITY SOCCER CAMPS/CLINICS
MEDICAL HISTORY/CONSENT and INSURANCE INFORMATION FORM

Camper Name: _____

Sex: _____ Age: _____ Date of Birth:_____

Please write name and date of camp/clinic: _____

Name of Parent/Guardian: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
If unable to reach Parent/Guardian in an emergency, please notify:

1._____ Phone: _____ Relationship_____

HEALTH HISTORY

Has/Does the participant: If "yes," please explain
1. have a current injury/illness/infectious disease? No Yes _____
2. have a chronic or recurring illness/condition? No Yes _____
3. ever been hospitalized? No Yes _____
4. ever had seizures/convulsions? No Yes _____
5. have diabetes? No Yes _____
6. have asthma? No Yes _____
7. have allergies? No Yes _____
8. had mononucleosis in the past 12 months? No Yes _____

Medications Currently Being Taken: (include both over-the-counter and prescription medications).
This participant takes medications as follows:
Med #1_____ specific times taken_____

Reason for taking_____ dosage_____

Med #2_____ specific times taken_____

Reason for taking_____ dosage_____

Attach additional pages for more medications.

INSURANCE INFORMATION

All participants must have their own medical/accident insurance coverage and notify the camp / clinic of any changes or cancellations.
Medical insurance company: _____ HMO____ PPO____

Policy number: _____ Group number: _____

Subscriber number: _____ Subscriber ID#: _____

Claims/Billing Address: _____

City, State, Zip Code: _____
If HMO or PPO, who is your Primary Care Physician? _____
Primary Care Physician phone number: _____

Parent/Guardian Consent:

This health history for _____ is correct to the best of my knowledge, and has permission to engage in all prescribed camp activities, except as indicated as "restrictions" previously stated on this document. In the case of any emergency where I cannot be reached, I hereby grant permission to Santa Clara University's Sports Camp/Clinic Program staff, assigned physicians and/or their consulting physician to render to my son or daughter any treatment, medical or surgical care that they deem reasonably necessary to ensure the health and well-being of my child named above.
I also hereby authorize the athletic trainers at Santa Clara University Sports Camp/Clinic to render to my child any preventative, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and well-being of my child named above.

_____ _____
Parent / Guardian Signature Date