

Health Information Form

(757) 221-3407

This form must be complete and on file with the workshop faculty before your child can participate in any workshop activity. Make sure it is brought to check-in so that the staff can review it at that time.

Camp: 2009 Colonial All-Pro Football Camp

Dates: June 21-24, 2009

Participant's Name _____ Age _____ Birthdate _____ Gender _____
(please print) last first M.I.

Address _____
Street _____

City _____ State _____ Zip _____

Participant's Social Security No. _____

Parent's Name _____

Home phone _____

Mother's Work phone _____

Father's Work phone _____

In an emergency, if parents cannot be contacted, notify:

Name _____ relationship to participant _____

Home phone _____ work phone _____

**If you are going to be on vacation or otherwise away from the above numbers while your child is at the workshop, please make a note to that effect and give alternate phone numbers.*

HEALTH HISTORY

Operations, serious illnesses, injuries--give dates and

outcomes _____

Allergies _____

Drug Allergies/sensitivities _____

Heat illness/Exhaustion _____ Asthma _____

Date of last Tetanus-Diphtheria Booster _____

List any special diet required and why _____

List any current medications and reason _____

MEDICAL INSURANCE INFORMATION

Complete name of insurance company: _____

Address where claim is to be mailed to: _____

Policy Holder's name: _____ Relationship to participant _____

Policy Holder's address _____

Policy Holder's Subscriber ID# _____ Policy Holder's group #(or name) _____

AUTHORIZATIONS--PLEASE READ CAREFULLY

* I certify that the above participant has had an official medical examination within the past year and is physically fit and able to participate in the rigors of this workshop.

* I hereby grant permission for my child to be medically treated for injuries or illnesses during his or her stay at the workshop.

* I authorize payment of medical benefits to all providers for all services and materials they provide during the care of an injury/illness.

*I understand that I am financially responsible for charges for services rendered for the care of an injury, and/or sickness/illness.

* A photostatic copy of this authorization shall be deemed as effective and valid as the original.

* I grant permission for the workshop faculty to administer the following indicated over-the-counter medications to my child. These may only be used for the signs and symptoms indicated below and only for a 24-hour period. After this time, a physician will be consulted and the workshop faculty will call me.

_____ Tylenol—for minor head aches (not thought to be associated with dehydration or head injury) and for fever less than 101⁰ F.

_____ Pepto Bismol—for stomach ache and diarrhea.

Signature of parent/guardian: _____ Date: _____