

2017 Women's Soccer Elite Summer Camp

CAMPER INFORMATION

LAST NAME	FIRST NAME	MI	
ADDRESS	CITY		
STATE	ZIP	CELL PHONE	HOME PHONE
HIGH SCHOOL	GRAD YEAR		
DOB	EMAIL ADDRESS		

CAMPER HEALTH FORM

I _____, understand that the consent and authorization herein granted do not include major surgical procedures and are valid only during the Camp. Physical conditions that the clinician should be aware of (allergies, recurring illness, disabilities, chronic illnesses, current medications) include:

CHECK ALL THAT APPLY

- | | |
|---|--|
| <input type="checkbox"/> Asthma (Inhaler) | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell |

Allergies to: _____
Last Physical Examination (Date): _____
Last Tetanus Immunization (Date): _____
Current Medications: _____
Chronic or Recurring Illnesses: _____
Operations/Injuries (Including dates): _____
Physical Restrictions: _____
Physicians Name/Phone Number: _____
Name of Insurance: _____
Policy Number: _____
Name of Policy Holder: _____

Parent/Guardian Signature _____ Date _____

For more information or any questions please contact Camp Director and Head Coach Kortney Rhoades at 302-857-7636

MEDICAL RELEASE

In case of an emergency, I understand that every attempt will be made to contact me. If contact is unsuccessful, I give my permission to any attending physician and medical service personnel to tender medical treatment to my child _____, including (if necessary) hospitalization. I understand further that any expense arising from injury shall be my responsibility. I hereby authorize the staff of the Camp to provide care that includes routine diagnostic procedures (i.e. x-rays, blood & urine test) and medical treatment as necessary to my child, _____ a minor. In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event that an emergency occurs, and if I cannot be reached, I give my consent for physicians and staff at Delaware State University, to perform any necessary emergency treatment. Delaware State University's Athletic Health Services agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. Accident insurance for the 2017 WOMEN'S SOCCER ELITE SUMMER CAMP is provided on an excess basis. All registrants must have their own primary medical insurance. Any medical claims will be the primary responsibility of the parent or guardian's medical coverage on an as needed basis.

Parent/Guardian Name (Print) _____

Emergency Contact Number _____

Parent/Guardian Signature _____ Date _____

PAYMENT

PAYMENT BY: CHECK CASH CREDIT CARD ONLINE

TOTAL AMOUNT ENCLOSED: \$ _____

NOTE: PLEASE MAKE CHECKS PAYABLE TO: **DELAWARE STATE UNIVERSITY WOMEN'S SOCCER**

PLEASE SEND CHECK AND APPLICATION TO:

WOMEN'S SOCCER
DELAWARE STATE UNIVERSITY
1200 NORTH DUPONT HIGHWAY
DOVER, DELAWARE 19901