2017 Women's Soccer Elite Winter 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

- ___ Asthma (Inhaler)
- ___ Bleeding Disorders
- ___ Convulsions
- ___ Diabetes
- ___ Concussions
- ___ Heart Disease
- ___ Rheumatic Fever
- ___ 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 WINTER 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

DelawareStateUniversity