

**MEDICAL FORM  
CAMP / CLINIC PROGRAMS  
MEDICAL HISTORY, TREATMENT PERMISSION AND RELEASE**

*Note: This form is required prior to participation in sport camps or clinics. Participation will not be permitted until this form has been completed and signed and is on file with the sports camp.*

**PLEASE PRINT USING BLACK INK**

**SPORT:**  ATHLETIC DEVELOPMENT     ALL SPORTS     BASEBALL     BASKETBALL  
 FIELD HOCKEY     FOOTBALL     GOLF     SOCCER     TENNIS     VOLLEYBALL     OTHER

**CAMP NAME:** \_\_\_\_\_ **CAMP DATE(S):** \_\_\_\_\_

**PARTICIPANT INFORMATION:**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
*First Middle Last*

**HOME ADDRESS:** \_\_\_\_\_  
*Street Address City State Zip*

**EMERGENCY CONTACT INFORMATION:**

**1. NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**PHONE:** Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**2. NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**PHONE:** Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

**FAMILY PHYSICIAN:** \_\_\_\_\_ **PHONE:** (\_\_\_\_\_) \_\_\_\_\_

**INSURANCE COMPANY:** \_\_\_\_\_ **ID NUMBER:** \_\_\_\_\_

**MEDICAL HISTORY (Please use back of this sheet if necessary) DATE OF LAST TETANUS BOOSTER:** \_\_\_\_\_

**Please identify any medical condition that would require special attention?** \_\_\_\_\_

**Is the participant under the care of a provider for a medical and/or psychological problem?** NO YES  
*If yes, please explain:* \_\_\_\_\_

**Is the participant taking medication prescribed by a health care provider?** NO YES  
*If yes, please explain:* \_\_\_\_\_

**ALLERGIES ⇒ If yes, please list the allergy and provide additional information if necessary.**

<b>Insect bites/stings</b>	<b>NO</b>	<b>YES</b>	_____
<b>Medications</b>	<b>NO</b>	<b>YES</b>	_____
<b>Food</b>	<b>NO</b>	<b>YES</b>	_____
<b>Other</b>	<b>NO</b>	<b>YES</b>	_____

**RELEASE OF LIABILITY:** I hereby release and discharge, indemnify and hold harmless the Regents of Wake Forest University, and their members officers, agents, employees, and any other persons or entities acting on the behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against all claims, demands, cost and expenses, and causes of action whatsoever, either in law or equity, arising out of or in any way connected with any property loss and/or bodily injury and/or disability, arising from my child's participation in the sports camp activities, including overnight stays on campus, if applicable.

**CONSENT FOR TREATMENT:** I hereby give my permission to a camp certified athletic trainer to supervise on-site first aid for minor injuries. In the event of injury such as broken limb, sprain, contusion, laceration, concussion, etc., or illness requiring medical diagnosis or treatment, I hereby give my consent for sports camp staff to secure the proper medical care; including transportation and hospitalization, if necessary. Every attempt will be made to contact the parent or guardian to inform you of the need for any medical attention beyond minor first aid, if necessary. Note: Overnight stays on campus may be supervised by camp counselors and not certified athletic trainers.

**PHYSICAL EXAMINATION WITHIN ONE YEAR:** I certify that within the past 12 months my child has had a physical examination by a physician and that he/she is physically able to participate in the sports camp activities.

**ASSUMPTION OF FINANCIAL RESPONSIBILITY:** I hereby acknowledge that I am responsible for medical charges incurred during sports camp participation. I further understand that the sports camp carries an excess medical insurance policy for sports injuries to the camper that may result from camp activities. Camp insurance has limits and exclusions and any secondary charges not covered under this plan will be my responsibility. This policy may only be utilized after my primary insurance company has processed the claims and issued an explanation of benefits.

**IMPORTANT: MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THESE TERMS**

**PRINT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP TO PARTICIPANT:** \_\_\_\_\_

**ADDITIONAL INFORMATION:**

**PLEASE ATTACH A COPY (FRONT & BACK) OF HEALTH INSURANCE CARD BELOW  
(RESIDENTIAL CAMPS ONLY)**