



ATHLETICS DEPARTMENT
MEDICAL INFORMATION FORM

Participant's Name: (Last) (First) (M.I.)

Birthdate: Social Security Number:

Current address:

Parent/Guardian Name:

Home Phone: Work Phone:

Emergency Contact and Phone Number:

Medical Insurance Information
Policy Holder's Name: Policy Number:
Insurance Company Name: Group Number:
Insurance Company Address:
Insurance Company's Phone:
Physician's Name: Phone Number:

Participant's Medical History

Mark all items "yes" or "no." Provide details when answer is "yes"

- Diabetes Drug Allergy
Food Allergy Insect Bite Allergy
Heart Defects Convulsions/Epilepsy
Asthma Current medications
Current doctor's care Physical restrictions
Date of last tetanus shot

Please list details related any items marked "yes," indicate current medications, list and physical limitations and/or restrictions, and describe any other current or past medical conditions that may require treatment.

Blank lines for medical details

The ATHLETICS DEPARTMENT requires that all participants in summer camps and programs complete and sign a MEDICAL INFORMATION FORM. If the participant is under the age of 18 a parent or guardian's signature is also required below.

Signature of Participant Date

Signature of Parent/Guardian Date