

**SANTA CLARA UNIVERSITY SPORT CAMPS  
MEDICAL HISTORY/CONSENT  
AND  
INSURANCE INFORMATION FORM**

Camper Name: \_\_\_\_\_  
Last
First
Middle

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Camp Sport: \_\_\_\_\_ Camp Date/Session: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number/Street
City
State
Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If unable to reach Parent/Guardian in an emergency, please notify:

1. \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

**HEALTH HISTORY**

Has/Does the participant:			If "yes," please explain
1. have a current injury/illness/infectious disease?	No	Yes	_____
2. have a chronic or recurring illness/condition?	No	Yes	_____
3. ever been hospitalized?	No	Yes	_____
4. ever had seizures/convulsions?	No	Yes	_____
5. have diabetes?	No	Yes	_____
6. have asthma?	No	Yes	_____
7. have allergies?	No	Yes	_____
8. had mononucleosis in the past 12 months?	No	Yes	_____

Medications Currently Being Taken: (include both over-the-counter and prescription medications).

- This participant takes NO medications on a routine basis.
- This participant takes medications as follows:
  - Med #1 \_\_\_\_\_ specific times taken \_\_\_\_\_
  - Reason for taking \_\_\_\_\_ dosage \_\_\_\_\_
  - Med #2 \_\_\_\_\_ specific times taken \_\_\_\_\_
  - Reason for taking \_\_\_\_\_ dosage \_\_\_\_\_

Attach additional pages for more medications.

Please list any restrictions for this participant while at camp:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION**

All participants must have their own medical/accident insurance coverage and notify the camp/clinic of any changes or cancellations.

Medical insurance company: \_\_\_\_\_ HMO \_\_\_ PPO \_\_\_  
Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_  
Subscriber number: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_  
Claims/Billing Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

If HMO or PPO, who is your Primary Care Physician? \_\_\_\_\_  
Primary Care Physician phone number: \_\_\_\_\_

**Parent/Guardian Consent:**

This health history for \_\_\_\_\_ is correct to the best of my knowledge, and has permission to engage in all prescribed camp activities, except as indicated as “restrictions” previously stated on this document.

In the case of any emergency where I cannot be reached, I hereby grant permission to Santa Clara University’s Sports Camp/Clinic Program staff, assigned physicians and/or their consulting physician to render to my son or daughter any treatment, medical or surgical care that they deem reasonably necessary to ensure the health and well-being of my child named above.

I also hereby authorize the athletic trainers at Santa Clara University Sports Camp/Clinic to render to my child any preventative, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and well-being of my child named above.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Acknowledgment of Risk and Release from Liability**

Participation in athletics requires an acceptance of risk of injury. I rightfully assume that those who are responsible for the conduct of the activity have taken reasonable precaution to minimize such risk to my child and that the other participants in the activity will not intentionally inflict injury upon him/her. I hereby assume all risks associated with participation in Santa Clara University Sports Camp/Clinics and agree to hold harmless Santa Clara University, its Sports Camp/Clinics, its directors, officers, employees, agents, representatives, coaches, volunteers, and athletic trainers from and against any and all claims, demands, losses or liability of any kind or nature which may arise in connection with injuries suffered to my child while participating in Santa Clara University Sports Camp/Clinic.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date