

UCSD SUMMER SPORTS CAMPS Medical/Insurance Information

Last Name _____		First Name _____		Age _____	Gender _____
Social Security # _____	Date of Birth _____	Camp(s) Enrolled In		Dates	
Parent/Guardian _____		1. _____		_____	
		2. _____		_____	
		3. _____		_____	
Home Address _____			City _____	State _____	Zip _____
In case of emergency, please notify:					
Name _____		Relationship _____	Home Phone _____	Cell/Work _____	
Health Care Carrier _____				<input type="checkbox"/> HMO	<input type="checkbox"/> PPO
Policy # _____		Name of Member _____			

HEALTH HISTORY (check/explain)		IMMUNIZATIONS (check if up to date)	
<input type="checkbox"/> Frequent ear infections _____	<input type="checkbox"/> Heart disease/defect _____	<input type="checkbox"/> DPT _____	<input type="checkbox"/> Rubella _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Oral polio _____
<input type="checkbox"/> Mononucleosis _____	<input type="checkbox"/> Bleeding/clotting disorders _____	<input type="checkbox"/> Measles _____	<input type="checkbox"/> Mumps _____
<input type="checkbox"/> Bed wetting problem _____	<input type="checkbox"/> Sleep walker _____	ALLERGIES (check/explain)	
<input type="checkbox"/> Convulsions _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Orthopedic/sports injuries _____	<input type="checkbox"/> Operations/serious illness _____	<input type="checkbox"/> Insect stings _____	<input type="checkbox"/> Penicillin _____
<input type="checkbox"/> Disability/recurring illness _____	<input type="checkbox"/> Dietary modification _____	<input type="checkbox"/> Food (please specify) _____	<input type="checkbox"/> Other _____
DISEASES			
Chicken Pox _____	Mumps _____	Measles _____	German Measles _____
Family Physician _____		Phone _____	
Family Dentist _____		Phone _____	
Has camper been exposed to a communicable disease within the last 21 days?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what disease? _____			
May camper have Tylenol (acetaminophen)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
MEDICAL RELEASE INFORMATION			
If your child is bringing medication to camp, please complete the following:			
Type of medication _____			
How to administer _____			
Purpose of medication _____			
Other comments _____			
Please note that the medication must be in original container with the label still intact			

PARENT/GUARDIAN AUTHORIZATION

The information stated above is correct as far as I know, and the individual herein described as "camper" has permission to participate in all camp activities except as noted. I hereby give permission to the medical personnel selected by UCSD Camp Staff to order x-rays, routine tests, treatment and necessary transportation for the above-named camper in the event that I cannot be reached in an emergency. I hereby grant permission to the medical personnel selected by UCSD to secure and administer treatment, including hospitalization, for the above-named camper. I FURTHER UNDERSTAND THAT IF I DO NOT HAVE MEDICAL INSURANCE, I WILL BE RESPONSIBLE FOR ANY MEDICAL COSTS INCURRED.

PARENT/GUARDIAN OR ADULT CAMPER SIGNATURE

DATE