

## Medical Treatment Form

It is the responsibility of the camper's parent(s) or guardian(s) to ensure that the camper is healthy and has no physical problems that would prevent their participation in all camp activities. This form must be completed before registration is complete.

Child's Name \_\_\_\_\_

Parent(s)/Guardian(s) Name \_\_\_\_\_

Address \_\_\_\_\_

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

Commuter \_\_\_\_\_ Resident \_\_\_\_\_

### **Emergency Contact**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

### **Medical Information**

Date of last Tetanus Immunization \_\_\_\_\_

Please list any allergies \_\_\_\_\_

Please list any medications taken within the last 6 months \_\_\_\_\_

Patient Medical History (i.e. chronic medical conditions, joint problems, dizziness or fainting spells) \_\_\_\_\_

**Please initial all non-prescriptions which you will allow a nurse of Certified Athletic Trainer to administer to your child...**

Acetaminophen (Tylenol) \_\_\_\_\_ Ibuprofen (Advil) \_\_\_\_\_

Triple Antibiotic Ointment \_\_\_\_\_ Benadryl \_\_\_\_\_

Cortisone Cream (first aid cream) \_\_\_\_\_

### **Medical Insurance Information**

Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Name Policy Is Under \_\_\_\_\_

Is this company a Preferred Organization of HMO? Yes \_\_\_\_\_ No \_\_\_\_\_

Does this company require pre-approval for medical treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

In the case of an emergency situation my child will be transported by EMS to the health care system of my choice in Spartanburg County. Circle one: Mary Black Health System or Spartanburg Regional Healthcare System.

I authorize any medical treatment that might be advised by a Certified Athletic Trainer, Nurse and/or Physician available at the Upstate Fastpitch Softball Camp while my child is present at the camp.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_