

Post2Post Soccer Camps

Consent for Medical Treatment For Minor Aged Visitors

(Please have parents complete form for their child. Please send form to camp office prior to arrival.)

In order to provide your son/daughter medical care in the event of illness or injury, you are requested to complete this form.

Student's Name _____

Address _____
Street City State Zip

Social Security # _____ Date of Birth _____

Name of Conference Attending _____

Father's Name _____

Telephone Number Home: () _____ Work: () _____

Mother's Name _____

Telephone Number Home: () _____ Work: () _____

Other Contact _____

Family Physician _____ Phone: () _____

Insurance Information

Carrier _____ Plan# _____ Policy# _____ Effective Date _____

Medical History:

1. Date of last tetanus booster _____
2. Does your child have any allergies to medications, foods, or insect stings? No Yes
If yes, please list: _____
3. Is your child under the care of a health care provider for a medical problem? No Yes
If yes, please explain: _____
4. Is your child taking medication prescribed by a health care provider? No Yes
If yes, please explain _____
5. Other information we should be aware of: _____

Parental Permission

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter by the University Health Center or any other medical facility. I understand that any health care facility will make every reasonable attempt to contact me first, time and conditions permitting. *I agree to be responsible for all charges incurred.*

Signed _____ Relationship _____ Date _____