

UC San Diego Sports Camps Medical Waiver

HS Team Name: Poway

Last Name _____ First Name _____ Age _____ Gender _____
 Social Security Number LEAVE BLANK Date of Birth _____
 Session Dates _____
 Parent/Guardian _____
 Address _____ City _____ State _____ Zip _____
 Emergency Contact _____ Relationship _____
 Emergency Contact Phone Number (Home) _____ (Work) _____
 Health Care Carrier _____
 Name of Member _____ Policy/Group Number _____
 Sport Camp _____

HEALTH HISTORY (Check/Explain)

- Frequent Ear Infections _____
- Heart Disease/Defect _____
- Diabetes _____
- Hypertension _____
- Mononucleosis _____
- Bleeding/Clotting Disorders _____
- Bed wetting problem _____
- Sleep Walker _____
- Convulsions _____
- Other _____
- Operations/Serious Illness _____
- Disability/Recurring Illness _____
- Dietary Modification _____

DISEASES

- Chicken Pox _____
- Mumps _____
- Measles _____
- German Measles _____

IMMUNIZATION

(Check if up to date)

- DPT _____
- Rubella _____
- Tetanus _____
- Oral Polio _____
- Measles _____
- Mumps _____

ALLERGIES (Check/Explain)

- Hay Fever _____
- Asthma _____
- Insect Stings _____
- Penicillin _____
- Food (Please Specify) _____
- _____
- Other _____
- Family Physician _____
- Phone _____
- Family Dentist _____
- Phone _____

Has camper been exposed to a communicable disease within the last 21 days?
 Yes ___ No ___ (If Yes, what disease? _____)
 May camper have Tylenol (acetaminophen)? Yes ___ No ___

MEDICAL RELEASE INFORMATION

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 _____