CAMPS & CLINICS SPORTS MEDICINE INFORMATION SHEET

****CAMPERS WILL NOT BE PERMITTED TO PARTICIPATE IN ANY ACTIVITIES UNTIL ALL REQUIRED FORMS ARE SUBMITTED****

Camp/Clinic Name: _____

Full Legal Name (FML): _____ DOB (MM/DD/YY): _____

Citizenship: _____ Gender (if willing to provide): _____

Primary Emergency Contact:

Name (First & Last): _____ Phone #:_____

Relationship to Camper: _____ Email: _____@_____

Secondary Emergency Contact:

Name (First & Last): _____ Phone #:_____

Relationship to Camper: _____ Email: _____@_____

Allergies/Reaction

Please list all allergies (medication, food, bee stings, poison ivy, etc.) and describe the nature of the reaction (rash, hives, difficulty breathing, etc.)

Injury History

Please list any injuries, including recent sprains, fractures, concussions, etc. and the date (MM/YY) the injury occurred.

Medical Conditions

Please list all medical conditions (asthma, diabetes, cardiac disorders, seizure disorders, sickle cell trait, history of heat illness or cramping, etc.).

Current Medications

Date of Last Tetanus Shot (MM/YY): _____

Insurance Information

INSTRUCTIONS: Please provide the below information or attach a copy of the front and back of your insurance card.

Policy Number: _____ Group Number: _____

Effective Date: _____ Termination/Renewal Date: _____

Type: ☐1) POS ☐2) PPO ☐3) HMO ☐4) MEDICAID ☐5) MILITARY ☐6) INTERNATIONAL

Insurance number to call to confirm benefits: _____

Please list any additional medical coverage: _____

Please fill out the below information for the **Policy Holder.**

Name & Relationship: _____Date of Birth: _____

Address: _____City, State & Zip: _____

Phone: _____Email: _____

☐ Please check this box if your personal health insurance policy is an out of state Medicaid policy (not from the state of Virginia).

☐ Please check this box if you do not have personal health insurance.