Pete Hovland's Competitive Swim Camp, LLC
Summer Camp Medical Form

SPORT: ____________________________________

DATE OF CAMP: ___________________________

Child's Name ________________________________ **Date of Birth** ___________________

Name of Parent(s)/Guardian(s) ____

Address ____
(city) (state) (zip code)

Phone Numbers (   ) ___________________ **Home** (   ) ___________________________

(   ) ___________________ (   ) ___________________________

Please indicate another person who would likely know where you can be contacted

Name __________________________ **Phone** (   ) ___________________________

If you plan to be away from home the week of your child is at camp, please indicate how you can be contacted: ____

____

********If my child needs medical treatment while participating at Pete Hovland Competitive Swim Camps, I give permission for treatment to be given immediately.**

Date ________________ **X** ________________________________

X ________________________________
Parents/Guardians Signatures

<u>MEDICAL INFORMATION</u>

1. Is your child presently on medication? **Yes** **No**

If so, what: ____

If so, why: ____

2. Drug Sensitivities: ____

____

3. Allergies: ____

____

4. Has your child had any medical problems in the past year which caused him/her to be hospitalized: Yes No
Please explain: ____

____

5. Has your child have any significant injuries? Yes No
Please explain: ____

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6. Date of last tetanus shot (if known): ______________________________
Month Year

7. Does your child have any problems that the medical staff of Pete Hovland Competitive Swim Camps should be alerted to? Yes No
Please explain: ____

<u>INSURANCE COMPANY</u>

Blue Cross/Blue Shield

Group # ____________ **Member's Name** ____________________

Policy # ____________ **Member's Address** ____________________

ID# ____________ ____________________

Service Code ______________

<u>OTHER INSURNACE</u>

Company ____________ **Employer's Name** ____________________

Group # ____________ **Employer's Address** ____________________

Policy # ____________ ____________________

Other ____________

PHYSICIAN'S SIGNATURE ______________________________________