



Dr. Jay Martin's
Super Soccer Camp
at Ohio Wesleyan University



SUPER SOCCER MEDICAL FORM

All participants attending *SUPER SOCCER CAMP* are required to complete and turn in this form at check-in on the first day of camp. Players can not participate until they complete this form. *SUPER SOCCER CAMP* urges immunization for diphtheria, tetanus, polio, measles, mumps and rubella.

SUPER SOCCER CAMP has a full-time athletic trainer on site all week. In addition, the Ohio Wesleyan Health Center will be available each morning. At all other times - day or night - all health related problems will be treated at the emergency room at Grady Memorial Hospital in Delaware, Ohio.

Please print or type.

Last Name _____ **First Name** _____

Home Address _____

Age _____ **Sex** _____ **Date of Birth** _____ **Email Address** _____

Name and relationship of person to contact in the case of emergency:

Name _____ **Relationship** _____ **Telephone** _____

Family Physician _____ **Telephone** _____

Health Insurance Information Required

Insurance Company _____ **Policy No.** _____

Address of Insurance Company _____

Authorization and Consent

I hereby agree that the attending physician may undertake treatment, including operation and/or administration of necessary anesthesia, in serious or major illness or injuries without prior notification or obtaining the consent of the undersigned or any other person if in the judgement of the physician or designee it is necessary, for health care, to proceed with treatment without delay. I further agree that all minor injuries may be treated as deemed necessary. It is further agreed that the camp may release any medical information to other physicians, to insurance companies etc. The authorization here does not diminish that provided by law.

Date _____ **Signature** _____



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Personal History **Please answer all questions!**

Have you had any of the Following?

Surgery Y N Date _____ Description _____

Illness Requiring Hospitalization Y N Date _____ Description _____

Chronic Illness Y N Date _____ Description _____

Allergies Y N Date _____ Description _____

Are you currently taking medication (including non-prescribed medication)? Please list

Medication	Reason for Taking Medication
_____	_____
_____	_____
_____	_____
_____	_____

**Is this child capable of carrying a full program of fitness activities, including soccer?
 If no, please state limitations**

**Is there anything else about the child that the camp should know? Do you have any
 recommendations regarding the care of this child? If yes, explain:**

Date _____ Parent or Guardian _____