

UC San Diego Sports Camps Medical/ Insurance Information

Enrolled in _____ sports camp

Last Name _____ First Name _____ Age _____ Gender _____ Date of Birth _____

Dates enrolled in camp(s):

1. _____ 2. _____ 3. _____

Parent/Guardian name _____

Address _____ City _____ State _____ Zip _____

In case of emergency, please notify:

Name _____ Relationship _____ (Home) _____ (Work) _____

Health Care Carrier _____ HMO ___ PPO

Policy Number _____ Name of member _____

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
- Orthopedic/sports injuries

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

If your child is bringing medication to camp, please complete the following:

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 (such as outings to: movies, beach, swimming pool, etc.) 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

SIGNATURE _____ DATE _____

Sport Camp & Dates: _____

Camper: _____

Date: _____

UC SAN DIEGO CAMPS CONCUSSION POLICY

- Any camper that sustains a head injury and experiences NO concussive symptoms, must sit out for 15 minutes.
- Any camper that sustains a head injury and experiences any of the symptoms of a concussion for any period of time, **must sit out for at least the remainder of the day and must be cleared by a physician (MD or DO of no relation to the camper)**. Symptoms may include, but are not limited to,
 - * headache
 - * double vision
 - * dizziness
 - * nausea or vomiting
 - * drowsiness
 - * memory problems
 - * sensitivity to light
 - * sensitivity to noise
- The camper must also be evaluated by the medical professional at the camp. Coaches do not count as medical professionals. The medical professional will determine the appropriate course of treatment following their examination of the camper.
- If the concussive symptoms are present, then the camper will be held out of all participation until evaluated by a Physician.
- **SEEING A PHYSICIAN**
 - The parent may choose to take the camper to the camper's personal physician (must be an MD or DO of no relation to the camper). The parent is responsible for making the appointment with the physician as well as driving the camper to the physician appointment.
 - If the parent cannot take the camper, one of the camp counselors will need to take the camper to the emergency room.
 - The camper and his/her family are responsible for all costs incurred as a result.
- Return to Play
 - A camper may not return to play until he/she has been symptom-free for at least 24 hours.
 - **AND**
 - The camper must provide documentation from the physician (both signed and stamped by the physician) detailing the exam as well as the physician's participation recommendations.

I acknowledge I have read and understand the UC San Diego Concussion Policy.

Parent Signature: _____

Date: _____