PARTICIPANT MEDICAL INFORMATION AND RELEASE FORM

Please print or type

Participant Name:_____

Date of Birth:_____
_____is not taking prescription medications.
_____is taking the following prescription medications:

_____for_____

_____for_____

_____for_____

Please list any nonprescription (over-the-counter) drugs the Participant is taking or is permitted to take including aspirin, acetaminophen, antihistamines, etc.).

_____for_____

_____for_____

_____for_____

Please list any recent or significant orthopedic conditions.

_____

The above-named student is covered by health & accident insurance as follows:

Policy Holder's Name _____

Relation to Camper _____

Insurance Company _____

Group/Policy Number _____ Plan # _____

Insurance Company's Phone Number_____

Physician: _____Phone Number: _____

Allergies: (food, drugs, insects, plants, etc.) _____No _____Yes Explain:

_____
_____

Are immunizations current? _____No _____Yes

Date of last Tetanus injection: _____

Does camper wear glasses or contact lens? _____No _____Yes

Please indicate if camper experiences or has experienced any of the following. Attach an additional sheet if additional space is needed for details.

Problem	**Yes**	**No**	**Not Known**	**Details** (how often, usual treatment, warning signs, etc.)
Headaches				
Convulsions/Seizures				
Fainting Spells				
Vision Problems				
Hearing Problems				
Breathing Problems				
Heart Problems				
Blood Clotting Problems				
Stomach/Bowel Problems				
Skin Problems				
Frequent Infections				
Diabetes				
Other				

*Soccer Camp is short for Joe Clarke / Washington University Soccer Camps.)

I/We hereby authorize the University and the *Soccer CP. to order emergency medical treatment on behalf of my/our child if deemed necessary by an adult camp staff member and/or qualified medical personnel. I/We give my/our permission to the University or adult camp staff of the *Soccer CP. to act on my/our behalf and administer the necessary medical care to my/our child. It is understood that all attempts possible will be made to contact me/us in the event that emergency care or otherwise is required. I/We understand that health care and accident expenses are not covered by the Camp and will be passed along to me/us.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Parent/Guardian Phone Numbers: Home (_____) _____

Work/Cell (_____) _____

Alternate Emergency Contact: Name _____

Phone (____) _____

Mail to: Joe Clarke, One Brookings Drive CB 1067, St Louis, MO 63130
Fax to: Joe Clarke, 314-935-5545
Email to: joec@wustl.edu