UNIVERSITY OF ILLINOIS at URBANA-CHAMPAIGN

WHIMC Summer Camp

EMERGENCY CONTACT and MEDICAL INFORMATION

Please choose one of the following methods to return this form.

- ❏ email to ginger@illinois.edu
- ❏ bring it on the first day of the camp

CAMPER INFORMATION:

NAME:____

ADDRESS:

____

Number / Street *City* *State* *Zip Code*

AGE: ____________GENDER:__________DATE OF BIRTH:____/____/_____

PARENT/GUARDIAN/OTHER:

NAME: ____

RELATIONSHIP: _______________________ ADDRESS:

____

Number / Street *City* *State* *Zip Code*

DAYTIME PHONE:(   )_________________ MOBILE PHONE:(   )_____________

EMERGENCY CONTACT:

NAME: __________________________RELATIONSHIP: ______________

ADDRESS:

____

Number / Street *City* *State* *Zip Code*

DAYTIME PHONE:(   )_________________ MOBILE PHONE:(   )_____________

HEALTH INFORMATION STATEMENT (OPTIONAL):

Check below and provide any information you feel the staff may need to maximize the safety and the well-being of the attendee. To the right of the condition statement is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate important information. This information is confidential.

[ ] Nervous or Mental (epilepsy, emotional stress, convulsion)

____

____

[ ] Lung Disease (asthma, persistent cough, tuberculosis) _____________________

____

[ ] Hay Fever or Allergies _______________________________________

[ ] Allergy to Medicines (including penicillin, tetanus) ____________________

[ ] Impaired Sight or Hearing, Chronic Ear Infections ____________________

[ ] Recent Surgical Operations, Accidents or Injuries ____________________

[ ] Skin Disease ____________________

[ ] Allergy to Foods

____

[ ] Does the Camper Wear Glasses? YES [ ] NO [ ] SOMETIMES [ ]

[ ] Does the Camper Wear Contact Lenses? YES [ ] NO [ ]

[ ] Date of last TETANUS BOOSTER ____________________

[ ] Other conditions program staff should be aware of ____________________

____

____

INSURANCE INFORMATION (OPTIONAL):

DOCTOR'S NAME: ____________________

CLINIC/HOSPITAL NAME: ____________________

CITY/STATE: ____________________PHONE: ( )____________________

HEALTH INSURANCE PROVIDER:

Name: ____________________

Address:

____

City / State Zip Code

NAME OF POLICY HOLDER:____________________DATE OF BIRTH:_____/_____/______

POLICY NUMBER: ____________________

_____As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be besought. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for medical treatment, as recommended by an attending physician.

_______I approve the release of medical information to WHIMC Staff and any treating physician.

_______I approve the release of insurance information to the health care provider (doctor, hospital of my child).

_______I approve the health care provider to release information to the insurance company.

_______I approve benefits from my insurance are payable to the health care provider.

_______If the benefits are paid directly to me, I will pay the health care provider.

_______I verify the above information is correct to the best of my knowledge.

_______My signature verifies the above information to be correct to the best of my knowledge.

SIGNATURE: ____________________DATE:____________________

(Parent or Guardian)

Parents/Guardians must complete and sign this form in order to finalize a camper's registration and allow participation in camp activities. A doctor's physical exam is not necessary-- general medical information is helpful, only contact information is required.