SAINT XAVIER UNIVERSITY

SUMMER CAMP HEALTH FORM

This form must be completed and returned to Auxiliary Services at least ONE week prior to the start of camp. Please fill out one form per participant. Completed forms should be emailed to Linda Moreno, director of Auxiliary Services, at moreno@sxu.edu.

Participant's Name: ____
(Last) (First) (Middle)

Email Address: ____

Gender: ❑ Male ❑ Female Date of Birth: ____________________

School attending this fall: ______________________________ Grade this fall: ________

Home Address: ____

City: ______________________________ State: ____________ Zip Code: ____________

Home Phone: (________) ____________________ Cell Phone: (________) ____________________

T-Shirt Size (Adult): ❑ S ❑ M ❑ L ❑ XL

WHICH CAMP WILL YOUR CHILD BE ATTENDING?

- ❑ Volleyball Camp
- ❑ Softball All-Skills Camp
- ❑ Youth Summer Lacrosse Camp
- ❑ Basketball Camp
- ❑ SXU-Southside Summer Jazz Camp
- ❑ Student Media Summer Camp
- ❑ Intro to Nursing Dual Credit Course
- ❑ Intro to Speech-Language Pathology Dual Credit Course
- ❑ Summer Logic Dual Credit Course

Will your child be carpooling with other camp attendees? ❑ Yes ❑ No

Who may pick up your child (if younger than 14 years of age)?

Name: ____

Phone: ____________________________ Relationship: ____________________________

Name: ____

Phone: ____________________________ Relationship: ____________________________

For security and safety reasons, your child will not be released to anyone not on this list.

EMERGENCY CONTACT INFORMATION

Name: ______________________ Relationship to Camper: ______________

Primary Phone: ______________________ Cell Phone: ______________________

Name: ______________________ Relationship to Camper: ______________

Primary Phone: ______________________ Cell Phone: ______________________

INSURANCE INFORMATION

Name of Policyholder: ____________________ Policy Number: ____________________

Primary Care Physician: ____________________ PCP Phone Number: ____________________

Is your policy: ❑ HMO ❑ PPO If yes, phone number for approval: ____________________

PERSONAL MEDICAL HISTORY

Does the participant have any allergies to medications, food, etc.? ❑ Yes ❑ No

Please list: ____

Does the participant currently take any prescription medications? ❑ Yes ❑ No

Please list: ____

Does the participant have any chronic health concerns? ❑ Yes ❑ No

Please list: ____

Has the participant's physical activity been restricted during the past five years? ❑ Yes ❑ No

Please explain: ____

Additional medical information that we should know: ______________________________

____

By signing below, I am stating that the above information is complete and truthful.

Parent/Guardian Signature: ________________________________ Date: ____________

Camper's Signature (if over 18 years old): ________________________ Date: ____________