



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 \_\_\_\_\_ Social Security \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephoned \_\_\_\_\_

**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?**

|  |            |                   |                          |
|--|------------|-------------------|--------------------------|
| <b>Surgery</b>                           | <b>Y N</b> | <b>Date</b> _____ | <b>Description</b> _____ |
| <b>Illness Requiring Hospitalization</b> | <b>Y N</b> | <b>Date</b> _____ | <b>Description</b> _____ |
| <b>Chronic Illness</b>                   | <b>Y N</b> | <b>Date</b> _____ | <b>Description</b> _____ |
| <b>Allergies</b>                         | <b>Y N</b> | <b>Date</b> _____ | <b>Description</b> _____ |

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

| <b>Medication</b> | <b>Reason for Taking Medication</b> |
|-------------------|-------------------------------------|
| _____             | _____                               |
| _____             | _____                               |
| _____             | _____                               |
| _____             | _____                               |

**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** \_\_\_\_\_