



2010 JUNIOR SEAHAWKS FOOTBALL CAMP

HILTON HEAD HIGH SCHOOL/ISLAND RECREATION CENTER

70 Wilborn Road
Hilton Head Island, S.C. 29926
843-689-4938

MEDICAL/INSURANCE FORM

1. Medical History

Camper's name: _____

List all medications the camper is currently taking:

List all medical conditions currently under treatment:

Does the camper have loss of a paired organ, such as a kidney or eye?

Yes _____ No _____

If yes, please list: _____

Is there any medical, behavioral or emotional condition or state that we should be aware of concerning your camper?

Yes _____ No _____

If yes, please describe: _____

Does the camper have any food allergies or dietary restrictions?

Yes: _____ No _____

If yes, please list: _____

Date of last tetanus immunization: _____

I hereby state that the Hilton Head Island Recreation Association/Strive to Excel, Inc./Beaufort County School District (the "Camp") is not responsible for any pre-existing injury or reoccurrence of any undisclosed pre-existing injury or illness of the above camper prior to the first day he/she registers. I understand that the Camp will assume responsibility only for injuries incurred while he/she is participating in camp activities under supervision during enrolled camp period, up to the limits of Camp insurance.

Signature of parent/guardian: _____

Date: _____

2. **Insurance Information**

The Camp provides primary excess coverage. Campers must provide the following information on their health/accident insurance:

Insurance Company : _____

Policy Number: _____

3. **Consent for Medical Treatment/Parental Permit-Release of Medical Information**

The law requires that parental permission be obtained for operative procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except emergency, without parents being contacted and fully informed.

I give permission for diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son/daughter.

I authorize release of any medical information to process insurance claims and request payment of benefits to the physicians or supplier for service described. I understand that should the insurance not cover this illness/injury, I will be responsible for payment in full of any charges incurred.

Signed: _____

Relationship: _____

Date: _____