MEDICAL INFORMATION

Medical Insurance Company Name & Policy No._______________________________________

Daytime Phone Numbers
Father: __________________________________
Mother: _________________________________

In an emergency, if parents cannot be reached please notify:
Name___________________________________
Relationship______________________________
Phone Number ___________________________

Family Doctor ____________________________
Phone Number ___________________________

Known Allergies___________________________
Asthma _________________________________
Diabetes ________________________________
Contact Lens _____________________________
Last Tetanus Shot or Booster ______________
List of Medications Currently Taking ___________

I, the undersigned parent or guardian, do hereby authorize the athletic trainer or coaches at the UAB Girls Soccer Camp to secure any and all medical treatment in the event that I cannot be contacted. I further authorize any attending physician to render any and all medical care which he or she may deem necessary.

It is understood that, in any event, an attempt will be made to contact the parent before treatment is started.

I, the undersigned parent or guardian, also certify that my child is physically fit to attend the UAB Girls Soccer Camp and participate in all camp activities.

________________________________________
Parent or Guardian Signature Date