UNIVERSITY OF ILLINOIS at URBANA-CHAMPAIGN  
SPORTS FITNESS PROGRAM  
EMERGENCY MEDICAL INFORMATION  
(*Sports Fitness Program Fax Number – 217-244-7322)  

*CAMPER INFORMATION:  
NAME: ____________________________________________________________  
ADDRESS: ____________________________________________________________  
                                           Number / Street / City State / Zip Code  
AGE: ___________ GENDER: ________ DATE OF BIRTH: _____ / _____ / ______  

*PARENT/GUARDIAN/OTHER:  
NAME:  ____________________________________________________________  
                  __________________________  
Relationship  HOME PHONE: (_____) _____________________ WORK PHONE: (_____)___________________________  
ADDRESS: ___________________________________________________________________________________________  
                                           Number / Street / City State / Zip Code  

*EMERGENCY CONTACT:  
NAME: ____________________________________________________________  
                  __________________________  
Relationship  HOME PHONE: (_____) _____________________ WORK PHONE: (_____)___________________________  
ADDRESS: ___________________________________________________________________________________________  
                                           Number / Street / City State / Zip Code  

*HEALTH INFORMATION STATEMENT:  
Check below 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) _________________________________ 
[ ] Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure__________________ 
[ ] Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever) ______________________ 
[ ] Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)________________________________________________________________________________ 
[ ] Arthritis, Kidney or Bladder Disease____________________________________________________ 
[ ] Hay Fever or Allergies____________________________________________________________________ 
[ ] Allergy to Medicines (including penicillin, tetanus) _____________________________________ 
[ ] Impaired Sight or Hearing, Chronic Ear Infections_________________________________________ 
[ ] Recent Surgical Operations, Accidents or Injuries__________________________________________ 
[ ] Any Infectious Disease__________________________________________________________________ 
[ ] Skin Disease_________________________________________________________________________ 
[ ] Allergy to Foods_______________________________________________________________________ 
[ ] Diabetes____________________________________________________________________________
[ ] Currently taking Medicines (list names and doses)
__________________________________________________

[ ] Medications that must be administered during the program and whether refrigeration is required
__________________________________________________

[ ] Under on-going care of Physician (NAME/PHONE #) for chronic/recurring problem
________________________________________________________________________________
________________________________________________________________________________

[ ] Does the Camper Wear Glasses? YES [ ] NO [ ] SOMETIMES [ ]
[ ] Does the Camper Wear Contact Lenses? YES [ ] NO [ ]
[ ] Date of last TETANUS BOOSTER__________________________________________________
[ ] Significant Orthopedic and/or Neuromuscular Impairment (e.g. loss of limb, spinal cord injury)
________________________________________________________________________________

[ ] Other conditions program staff should be aware of
________________________________________________________________________________
________________________________________________________________________________

*INSURANCE INFORMATION:

FAMILY 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
  sought. 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 the Sports Fitness Medical 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.
  ▪ I also understand the $1,000 maximum accident coverage in effect while at the University of Illinois
    campus does not cover pre-existing conditions, self-inflicted injuries, or illnesses. Medical treatment must
    be rendered and claims must be submitted within 45 days of the conclusion of the camp.
  ▪ 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 campers registration and allow participation in
camp activities A doctor’s physical exam is not necessary—only general medical information is required

Mail the form to:
University of Illinois Sports Fitness Program
119 Freer Hall
906 South Goodwin Avenue
Urbana, IL 61801

OR
Fax to: (217) 244-7322
Attention: Sports Fitness Program