SBU SOCCER SCHOOL INSURANCE AND MEDICAL INFORMATION FORM

Name of Participant: _____ Participant's Date of Birth: _____

Participant's Emergency Contact _____(_____)_____
Name Phone Number Relationship

Participant's Emergency Contact: _____(_____)_____
Name Phone Number Relationship

Participant's Insurance Company: _____ Policy Number: _____

****Please attach a copy of insurance card**

Policy Holder: _____ Policy Holder's Relationship to Participant: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security Number: _____

Policy Holder's Address (if different from Participant's)_____

List of Current Medications: _____

Does the Participant require assistance in taking any medication? _____ Yes _____ No
**If you answered yes, please attach a sheet to this form detailing the name of the medication, when and how often it is supposed to be taken, and the dosage amount.

List of Allergies: _____

List of Physical Disabilities/Restrictions: _____

I, _____, state that I have completed the Medical Information Form and have completely and accurately disclosed all of the information requested herein. I further acknowledge that in the event of an emergency, this information will be provided to a healthcare provider in order to allow said provider to render medical treatment to the Participant. I acknowledge that the only knowledge Southwest Missouri Sports Camps, Inc. has of the Participant's medical condition is contained in the information that I have provided on this Form.

_____ DATE: _____

Signature of Participant or Guardian of Participant