***If you already have a school physical you can attach it to this one and fill out and sign this one at the bottom.

REDFERN HEALTH CENTER CLEMSON UNIVERSITY

SPECIAL GROUPS AND CAMPERS

CAMP PHONE NUMBER: ** (864) 637-8474 **

We have moved the Camp Office so if you can not get through on the Camp Phone, please visit our website for the new number

CAMP FAX NUMBER: (864) 656-7324

(Return when you come to camp or return to: PO Box 31, Clemson, SC 29633

Please print: Complete all information where applicable.

**Please read and sign back form as well

Name of Special Event/Group Attending: Monte Lee Baseball Camps

Participant's Name: ______________________________

Address: ______________________ Social Security No. _____/ _____ /_______

______________________ Date of Birth ______________________

______________________ Male ___________ Female _____________

Full Name of Parent/Guardian:______________________________

(Address, if different from above)______________________________

Home Telephone: ( )_____________ Business Telephone: ( )_____________Cell ( )_____________

If not available in an emergency, notify______________________ Telephone # _______________

- Parent(s) signature (indicates you have accident insurance): ______________________
- Name and address of your insurance company: ______________________

____

______________________Insurance Co. Phone #: ______________________

Insurance Co. Policy #: ______________________________

Medical History

(To be completed by Parents or Self)

A. List all medications patient is currently taking

____

____

B. List all medical conditions currently under treatment

____

____

C. Does patient have loss of a paired organ, i.e., kidney, eye? Yes ________ No _________

If yes, list______________________

____

D. Is patient allergic to any medications?

Yes ___________ No __________

If yes, list ______________________

E. Date of lst tetanus immunization:__________

I herby state that the Monte Lee Baseball Camps is not responsible for any pre-existing injury or reoccurrences of any undisclosed pre-existing injury or illness of the above camper prior to the first day the camper registers.

***______________________________

(Signature of Parent/Guardian) (Date)

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 my permission for such 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 of any medical information to process insurance claims and request payment of benefits to the physician or supplier for services 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 ______________________

PHYSICIAN'S STATEMENT

I hereby certify that I have examined

____

and found him/her physically fit to attend and participate in the camp and I know of no impairments which would limit his/her participating.

DATE EXAMINED:______________________

**PHYSICIAN'S SIGNATURE:______________________

ADDRESS: ______________________