

OAKLAND GIRLS SOCCER CAMPS L.L.C
Summer Camp Medical Information and Release for Treatment

Date of Camp: _____

Child's Name: _____

Date of Birth: _____

Parent(s)/Guardian(s) Name: _____

Home Address: _____

Telephone #: _____ Work #: _____ Cell #: _____

Secondary Contact Source in Case of Emergency: Name _____

Telephone #: _____ Work #: _____ Cell #: _____

**** If my child needs medical treatment while participating at Oakland Soccer Camps, I give my permission for treatment to be given immediately.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Insurance Information

Insurance Co.: _____ Member's Name: _____

Group #: _____ Policy #: _____

ID #: _____ Service Code: _____

Medical Information

1. If your child is presently taking any medication, please indicate what type and why: _____

2. Please list any drug sensitivities: _____

3. Please list any allergies: _____

4. Please list your child's medical problems and/or significant injuries that the medical staff at Oakland Soccer Camps should be made aware of: _____

5. Date of your child's last tetanus shot (if known): _____

Thank you for your cooperation in filling out this important emergency information

Oakland Girls Soccer Camps L.L.C
36 Arizona Avenue, Rochester Hills, MI 48309