Grand Canyon University
Athletic Camp/Clinic Sports Medicine Information Sheet

Section A-D: To be filled out by parents (please print/type)

Section A:
Name of Participant: _____Name of Camp attending:_____
Date of Birth:_____Age:_____Height:_____Weight:_____

Please provide the following medical information for your child:

Primary Emergency Contact

Name _____

Relationship _____

Phone Number _____

Secondary Emergency Contact

Name _____

Relationship _____

Phone Number _____

List any allergies:
Is the camper allergic to any medication? _____
If yes, please explain reaction: _____
Is the camper under the care of a physician or taking any medications? _____
If yes, please explain which medication and for which condition:
_____
Does the camper have any of the following frequently or is he/she a victim of any of the following:
_____ Nosebleeds _____Stomach Cramps _____Epilepsy _____Heart Condition
_____Diabetes _____ Seizures

**No medication will be administered or dispea

Parent's/Guardian Signature: _____

Family Physician's Name: _____

Physicians' Phone number: _____

GCU Athletic Summer Camp
CONSENT FOR MEDICATION ADMINSTRATION

Camper Name _____

To The Parent(s) or Legal Guardian:
If your child is under the age of 18, the GCU athletic summer camps requires your consent for medication administration or for your child's use of medical devices. The medication prescribed, non-prescribed/over the counter medicine, and/or medical device must be administered by the camp athletic trainer.

All medications must be in the original or separate medicine bottles and labeled with the camper's name. Prescription medication(s) must also include on the label the doctor's name and phone number, the medication name, and the dosage.

Complete the following information by *initialing* A, and/or B:

_____ A. There will be **NO** prescription medication(s), non-prescription(s) and/or medical devise(s) brought to camp.

_____ B. There will be the following **PRESCRIPTION** medication(s) and/or medical devise(s) brought to camp (use back of this form if needed).

Name of Medication	
Condition	
Dosage	
Time/Days to be Taken	
Prescribing Doctor	
Doctor Phone Number	
Special Instructions	

If the camper's medication is for life-threatening conditions and needs to be carried by the camper, please initial below and see the Camp Director at the check-in counter to confirm the medication plans.

_____ The medication listed above for life threatening conditions may be carried by my child (age 15 and under). Please list life threatening condition below.

ALL PARENTS/GUARDIANS **must** sign below that they have read the medication administration form and have completed it.

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____ Phone Number: _____