CU COMMUNITY FAB LAB

EMERGENCY CONTACT AND MEDICAL INFORMATION

Only one form needs to be submitted per camper if registering for multiple camps. Please complete and return this form by one of the following methods:

Email:
communityfablab@gmail.com

Mail:
CUC Fab Lab
1301 S Goodwin Ave,
Urbana, IL 61801

In Person:
Bring it with you the first day of camp

CAMPER INFORMATION:

NAME: _____

ADDRESS: _____
Number / Street *City* *State* *Zip Code*

AGE: _____GENDER:_____DATE OF BIRTH:_____/_____/_____

PARENT/GUARDIAN/OTHER:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
Number / Street *City* *State* *Zip Code*

DAYTIME PHONE:( )_____ MOBILE PHONE:( )_____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
Number / Street *City* *State* *Zip Code*

DAYTIME PHONE:( )_____ MOBILE PHONE:( )_____

HEALTH INFORMATION STATEMENT:

Check below and provide 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) _____
☐ Hay Fever or Allergies _____
☐ Allergy to Medicines (including penicillin, tetanus) _____
☐ Impaired Sight or Hearing, Chronic Ear Infections _____
☐ Recent Surgical Operations, Accidents or Injuries _____
☐ Skin Disease _____

☐ Allergy to Foods _____

☐ Does the Camper Wear Glasses? ☐YES ☐NO ☐SOMETIMES

☐ Does the Camper Wear Contact Lenses? ☐YES ☐NO

☐ Date of last TETANUS BOOSTER _____

☐ Other conditions program staff should be aware of _____

_____

INSURANCE INFORMATION:

DOCTOR'S NAME: _____

CLINIC/HOSPITAL NAME: _____

CITY/STATE: _____ PHONE: ( )_____

HEALTH INSURANCE PROVIDER:

NAME: _____

ADDRESS: _____

Number / Street *City* *State* *Zip Code*

NAME OF POLICY HOLDER:_____ DATE OF BIRTH:_____/_____/_____

POLICY NUMBER: _____

INITIAL HERE _____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.

INITIAL HERE _____I approve the release of medical information to the CU Community Fab Lab Camp Staff and any treating physician.

INITIAL HERE _____I approve the release of insurance information to the health care provider (doctor, hospital of my child).

INITIAL HERE _____I approve the health care provider to release information to the insurance company.

INITIAL HERE _____I approve benefits from my insurance are payable to the health care provider.

INITIAL HERE _____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.

INITIAL HERE _____If the benefits are paid directly to me, I will pay the health care provider.

INITIAL HERE _____I verify the above information is correct to the best of my knowledge.

INITIAL HERE _____My signature verifies the above information to be correct to the best of my knowledge.

SIGN HERE

SIGNATURE: _____DATE:_____

(Parent or Guardian)

Parents/Guardians must complete and sign this form to finalize a camper's registration and allow participation in camp activities. A doctor's physical exam is not necessary--only general medical information is required.