



2018

JULY 6th & 7th

\$ 60

**8-9 am
(check in)**

**9-12 pm
(camp)**

FOR ALL POSITIONS/RISING 1st-8th GRADES

Pre-registration Will pay day of camp

Name of Camper

Age _____ DOB _____ Grade in fall _____

Camper T-shirt Size (Circle One)

Y/SM Y/MD Y/LG A/SM A/MD A/LG A/XL

Mailing address

City _____ ST _____ Zip _____

Parents Name

Parents Phone

Parents Email

MAKE CHECKS PAYABLE TO:

MIKE MINTER CAMPS, LLC

MAIL PAYMENTS AND MEDICAL FORM TO:

CAMPBELL UNIVERSITY FOOTBALL

PO BOX 10

BUIES CREEK, NC 27506

JUNIOR CAMEL'S FOOTBALL CAMP

This camp designed for children and teenagers to learn about the game of football and/or improve athletic skills. During the instruction sessions, campers are under the close supervision of experienced staff of college coaches and athletic trainers.

CAMPERS WILL NEED

Signed medical form (found on the backside of this flyer or online at gocamels.com), registration form or receipt, and cleats.



HEAD COACH

Coach Mike Minter is a veteran NFL player who has coached at the high school and college level. He was introduced as the second head coach in Campbell Football History on November 27, 2012. Coach Minter looks to grow the minds of young children to love the game of football.

Campbell University Athletic Camp Medical Information

This form MUST be completed and returned in order to participate in the sports camp

Sport: _____ Camp Name: _____ Camp Date(s): _____

Participant Name: _____ Date of Birth: _____ Male / Female (please circle)

Home Address: _____
 (Street) _____ (City) _____ (State) _____ (Zip) _____

Parent/Guardian Name: _____ Parent/Guardian Phone No: _____

Emergency Contact: _____ Emergency Phone No: _____

Relationship to Participant: _____

Pre-Existing Conditions (Please circle if the participant is known to have):		Allowed Medications - to be dispensed only by Campbell University Health Center (please circle all that apply to the participant):					
Asthma	Epilepsy/ Seizures	Sudafed	Yes	No	Advil (Ibuprofen)	Yes	No
Diabetes	High Blood Pressure	Tylenol	Yes	No	Pepto Bismol	Yes	No
Sickle Cell	Dizziness/ Fainting	Maalox/ Antacid	Yes	No	Benadryl (25mg)	Yes	No
Hypoglycemia							
Other Conditions or allowed medications (please specify): _____							

Allergies: _____

Date of last tetanus immunization: _____

Additional health-related problems (list and explain in detail): _____

Medication regularly taken by the participant (please list all medications and dosages): _____

****PLEASE NOTE:** Only medications listed on this form may be possessed and taken by the minor while at camp unless prescribed by a university health center provider. All prescription medications must be brought **in the original bottle** and will only be administered as directed on the bottle unless accompanied by a doctor's note. **

By signing this document, I certify that within the past year the aforementioned participant has had a physical examination by a physician, or other licensed medical provider, and that he/she is physically able to participate in the sports camp/clinic activities.

Additionally, by signing this document, in the event of an injury, illness, and/or accident involving my son/daughter, I hereby give my consent for medical treatment(s) at Campbell University Health Center. I hereby give my consent to: a certified athletic trainer and/or his/her designee to render and supervise on-site first aid treatments, to the appropriate camp/clinic personnel to properly transport my son/daughter to an appropriate medical facility for care, and to a licensed physician to hospitalize and secure proper treatment(s) for my son or daughter, including injections, diagnostic procedures, anesthesia, surgery, and/or other reasonable and necessary procedures. I hereby authorize my health insurance company to pay for benefits and for the cost of such treatment(s). I also authorize the disclosure of medical information to my insurance company for the purpose of any claim.

Parent/Legal Guardian's Signature: _____ Date: _____

Insurance Information

Policy Holder: _____ Date of Birth: _____ Last 4 of SSN: _____

Company: _____ Policy No: _____ Group No: _____

Insurance Company Phone Number: _____