MISSOURI STATE SOCCER SCHOOL INSURANCE AND MEDICAL INFORMATION FORM

Name of Participant:		Participant's Date of Birth:	
Participant's Emergency Contact:	Jame	()Phone Number	Relationship
Participant's Emergency Contact:	Jame	()Phone Number	Relationship
Participant's Insurance Company:		Policy Number:	
Policy Holder:	Policy H	older's Relationship to Participant:	
Policy Holder's Date of Birth:	Po	olicy Holder's Social Security Number:	
Policy Holder's Address (if different from Par	ticipant's):		
List of Current Medications:			
Does the Participant require assistance in takin **If you answered yes, please attach a sheet to to be taken, and the dosage amount.		ion? Yes No ailing the name of the medication, when and how	often it is supposed
List of Allergies:			
List of Physical Disabilities/Restrictions:			
accurately disclosed all of the information req information will be provided to a healthcare p	uested herein. rovider in orde west Missouri	ve completed the Medical Information Form and I further acknowledge that in the event of an emer r to allow said provider to render medical treatme Sports Camps, Inc. has of the Participant's medica m.	gency, this nt to the Participant.
Signature of Participant or Parent or Guardian	of Participant	DATE:	
F	Return to:	Missouri State Soccer School P.O. Box 7055 Springfield MO 65801-7055	

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