

**Chuck Kriese's Total Tennis Training Camp
Printable Medical Form**

**Print, Fill Out, and Mail or Bring To:
Total Tennis Training Camp
324 Foxglove Drive
Nashville, TN 37211**

Please PRINT or TYPE (USE ONE FORM PER CAMPER)

Complete all information where applicable. If no form is submitted, one application will be sent in the mail.

NAME _____ WEEK(S) ATTENDING _____
Last First Middle

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

DAY PHONE (____) _____ - _____ NIGHT PHONE (____) _____ - _____

BIRTHDATE ____/____/____ SEX _____

PARENT/ GUARDIAN FULL NAME _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

DAY PHONE (____) _____ - _____ NIGHT PHONE (____) _____ - _____

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY _____

PHONE (____) _____ - _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

HEALTH INSURANCE COMPANY NAME _____

POLICY NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

MEDICAL HISTORY
(To be completed by Parents or Camper)

List all medications camper is currently taking

List all medical conditions currently under treatment

Does camper have loss of paired organ, i.e./ kidney, eye? YES _____ NO _____

If yes, what organ(s) _____

Date of last tetanus immunization _____

I hereby state that Chuck Kriese's TOTAL TENNIS TRAINING CAMP® is not responsible for any pre-existing injury or illness of the above camper prior to the first day the camper registers, and Chuck Kriese's TOTAL TENNIS TRAINING CAMP® will assume responsibility only for injuries or illness occurred while the above camper is participating in camp activities under supervision during enrolled camp period, up to the limits of the purchased camp insurance.

(Signature of Parent/Guardian)

(Date)

CONSENT FOR MEDICAL TREATMENT/PARENTAL PERMIT/RELEASE OF MEDICAL INFORMATION

The law requires that parental permission be obtained for operative procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except emergency, without parents being contacted and fully informed.

I give permission for such diagnostic, therapeutic, and operative procedure as may be deemed necessary for my son/daughter.

I authorize release of any medical information to process insurance claims and request payment of benefits to the physicians or supplier for services described. I understand that should the insurance not cover this illness/injury, I will be responsible for payment in full of any charges incurred.

Signed _____

Relationship _____

Date (____) _____ - _____

PHYSICIAN'S STATEMENT

I hereby certify that I have examined _____, and found him/her physically fit to attend and participate in Chuck Kriese's TOTAL TENNIS TRAINING CAMP®. I know of no impairments which would limit his/her participating in all camp activities.

Physician's Signature _____

Date Examined _____ Phone: (____) _____ - _____

Address _____

City _____ State _____ Zip Code _____ Country _____