MEDICAL FORM: 2012 PROGRAMS
MEDICAL HISTORY, TREATMENT PERMISSION AND RELEASE

Note: This form is required prior to participation in camps/clinics. Participation will not be permitted until this form has been completed and signed and is on file with the program director.

PLEASE PRINT USING BLACK IN

CAMP/CLINIC NAME: _____
CAMP/CLINIC DATE: _____

PARTCIPANT INFORMATION

NAME:_____ AGE:_____ DATE OF BIRTH:_____
First Middle Last

HOME ADDRESS:_____ _____ _____ _____
Street address City State Zip code

FATHER/GUARDIAN NAME: _____

ADDRESS: _____

PHONE: *Home* (____)_____*Work* (____)_____ *Cell*(____)_____

MOTHER/GUARDIAN NAME: _____

ADDRESS: _____

PHONE: *Home* (____)_____*Work* (____)_____ *Cell*(____)_____

OTHER/EMERGENCY CONTACT PERSON NAME:_____

PHONE: *Home* (____)_____*Work* (____)_____ *Cell*(____)_____

FAMILY PHYSICIAN:_____ PHONE: (___)_____

INSURANCE COMPANY: _____ ID #: _____

MEDICAL HISTORY (Please use back of sheet if necessary)

DATE OF LAST TETANUS BOOSTER: _____

Is the participant under the care of a provider for a medical and/or psychological problem? NO YES
If yes, please explain _____

Is the participant taking medication prescribed by a health care provider? NO YES
If yes, please list and explain _____

ALLERGIES: If yes, please list the allergy and provide additional information if necessary

Insect bite/sting	NO	YES
Medications	NO	YES
Food	NO	YES
Other	NO	YES

RELEASE OF LIABILITY: I hereby release and discharge, indemnify and hold harmless the camp directors and employees, and any other persons or entities acting on the behalf, and the successors and assigns for any and all of the aforementioned person and entities, against all claims, demands, cost and expenses, and causes of action whatsoever, either in law or equity, arising out of or in any way connected with any property loss and/or bodily injury and/or disability, arising from my child's participation in camp/clinic activities, including overnight stays on campus if applicable.

CONSENT FOR TREATMENT: I hereby give my permission to a camp/clinic certified athletic trainer to supervise on-site first aid for minor injuries. In the event of injury such as broken limb, sprain, contusion, laceration, concussion, etc. or illness requiring medical diagnosis or treatment, I hereby give my consent for sport camp/clinic staff to secure the proper medical care; including transportation and hospitalization, if necessary. Note: overnight stays on campus may be supervised by camp/clinic counselors and not certified athletic trainers.

PHYSICAL EXAMINATION WITHIN ONE YEAR: I certify that within the past 12 months my child has had a physical examination by a physician and that he/she is physically able to participate in the sports camp activities.

ASSUMPTION OF FINANCIAL RESPONSIBILITY: I hereby acknowledge that I am responsible for medical charges incurred during camp/clinic participation. I further understand that the sports camp/clinic carries an excess medical insurance policy for sports injuries to the camper that may result from camp/clinic activities. Camp/clinic insurance has limits and exclusions and any secondary charges not covered under this plan will be my responsibility. This policy may only be utilized after my primary insurance company has processed the claims and issued an explanation of benefits.

IMPORTANT: MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE TERMS

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

RELATIONSHIP TO PARTICIPANT: _____

ADDITIONAL INFORMATION: