

Medical Waiver Form

This form MUST be completed and returned to the Camp prior to YOUR participation in the selected camp. YOU WILL NOT BE ADMITTED WITHOUT THIS FORM COMPLETED IN ITS ENTIRETY.

Camp Details

Camp Name: _____	Camp Date: _____
Camp location: _____	

Camper Details

Campers Name: _____	Date of Birth: _____	Age: _____
Camper Address: _____		

Emergency Contact

Contact 1	
Name: _____	
Phone #: _____	Cell Phone #: _____
Address: _____	
Email: _____	
Contact 2	
Name: _____	
Phone #: _____	Cell Phone #: _____
Address: _____	
Email: _____	

Medical Information

Has the camper had any of the following? (Please tick if true)

<p><u>Medical</u></p> <p>Chicken Pox _____ <input type="checkbox"/></p> <p>Diabetes _____ <input type="checkbox"/></p> <p>Measles _____ <input type="checkbox"/></p> <p>Asthma _____ <input type="checkbox"/></p> <p>Epilepsy _____ <input type="checkbox"/></p> <p>Other: _____</p> <p>_____</p> <p>_____</p>	<p><u>Immunization (include dates)</u></p> <p>Tenanus Toxioid _____</p> <p>Tuberculin Test _____</p> <p>Measles / Rubella _____</p> <p>Polio Vaccine _____</p> <p>Other: _____</p> <p>_____</p> <p>_____</p>	<p><u>Allergies</u></p> <p>Insect Stings _____ <input type="checkbox"/></p> <p>Penicillin _____ <input type="checkbox"/></p> <p>Antibiotics _____ <input type="checkbox"/></p> <p>Other: _____</p> <p>_____</p> <p>_____</p>
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Will the camper be taking any medication during camp?

Please list any medications and in what quantity they should be administered?

Are there any medical conditions that will require special attention? If so – please explain?

Physician's Name: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Insurance Information

Insurance Carrier: _____ Policy Number: _____
Policy Holder Name: _____ Group Number: _____

Liability Waiver

In signing this waiver of liability, I release (Put Camp Name here) _____ the host institution, and all other involved parties from any claims or responsibility for injuries suffered in (Put Camp Name here) _____ Camps. I knowingly assume all risks associated with participation, even if arising from negligence of the participants or others, and assume FULL responsibility for my participation. I certify that I am in good physical condition and can participate in this lacrosse camp. Further, I authorize the site director to request medical treatment as necessary to insure my well-being.

Athlete Signature: _____

Print: _____ Date: _____

Parent Signature: _____

Print: _____ Date: _____