

PRO PLAYER LACROSSE CAMPS

MEDICAL RELEASE FORM

Name of Applicant: _____ Date of Birth: _____ E-Mail _____
Home Address/Phone: _____
Parents/Guardians: Mother: _____ Father: _____
Home Address/Phone: _____
Work Phone/Beepers: Mother: _____ Father: _____

IN CASE OF ACCIDENT/EMERGENCY NOTIFY:

Name/Relationship to Child: _____ Phone: _____
1st Alternate Name/Relationship to Child: _____ Phone: _____
2nd Alternate Name/Relationship to Child: _____ Phone: _____

MEDICAL EMERGENCY AUTHORIZATION

I hereby authorize PRO PLAYER LACROSSE to arrange for emergency medical treatment for my child, while my child is under the Camp's care. I understand that in the event I cannot be reached, I hereby consent to and authorize the physician and hospital selected by the PRO PLAYER LACROSSE Supervisor to hospitalize, secure proper treatment for, to order injection, anesthesia, surgery and any preliminary, further and additional treatments, procedures, tests, etc., that may be in the judgment of the doctor and/or hospital advisable or necessary at the time, for my child, as named above. I hereby authorize the PRO PLAYER LACROSSE Director to administer over-the-counter medication (Tylenol, Dramamine, Pepto Bismol, etc.) and first aid for minor injuries as deemed necessary.

Parent/Guardian Name (print): _____
Parent/Guardian Signature: _____ Date: _____

INSURANCE FORM

Coverage for accidental injury is required by all participants. In most instances, family health insurance is adequate. The camp provides only excess coverage after your insurance policy has been utilized. Please indicate the name/address/phone of your family health insurance carrier below:

Insurance Carrier: _____
Address: _____
Phone: _____ Insured: _____
Policy Group No.: _____ ID No.: _____

LIABILITY RELEASE

In consideration of my attendance, I, the undersigned participant, intending to be legally bound, do hereby for myself, my heirs, executors, and administrators, waive, release and forever discharge any and all rights and claims for damages which I, or any of us may hereafter have against PRO PLAYER LACROSSE, or its respective officers, agents, representatives, and/or assigned for any damages which may be sustained or suffered by me in connection with or entry in and/or arising out of my travelling to participation and return from the academy.

Signature: _____ Date: _____

CHILD'S NAME: _____

D/BIRTH: _____

IMMUNIZATIONS:
Include All Dates

DTP	DATE	1ST / /	2ND / /	3RD / /	BOOSTER / /	BOOSTER / /
ORAL POLIO	DATE	1ST / /	2ND / /	3RD / /	BOOSTER / /	BOOSTER / /
HIB (conjugate)	DATE	1ST / /	2ND / /	3RD / /	4TH / /	
HEPATITIS B	DATE	1ST / /	2ND / /	3RD / /		
MMR	DATE	1ST / /	2ND / /			
Other Immunization	DATE	Type _____	_____	_____	_____	_____

Tuberculin Test (Type) _____ Results: _____ Date: _____

PHYSICAL EXAMINATION:
(Please Check and Describe Positive Findings)

Height: _____ Weight: _____ Skin & Scalp: _____

Nose & Throat: _____ Heart & Lungs: _____ Abdomen: _____

- Are there allergic Problems? Yes No
If Yes, specify: _____
- Is there a special diet required? Yes No
If Yes, specify: _____
- Is medication regularly taken? Yes No
If yes, specify: _____
- Has your child ever had chicken pox? Yes No
If yes, specify: _____
- Are there any conditions requiring special attention? Yes No
If yes, specify: _____

DOCTOR'S NAME: _____

ADDRESS: _____

PHONE: _____

The above-named child was examined and found to present no hazard from contagious and communicable disease, and is in good health, and is able to participate in the customary camp activities.

Date of Examination: _____ Signature of Doctor: _____