MILLON LACROSSE CAMP AND Ohio Wesleyan University

MEDICAL RELEASE FORM

Name of Applicant: _____ **DOB:** _____ **E-MAIL**_____

Home Phone: _____

Parents/Guardians: **Mother:** _____ **Father:** _____

Cell #s : **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 MILLON LACROSSE CAMP AND Farmingdale State College 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 MILLON LACROSSE Director/trainer 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 MILLON LACROSSE CAMP Director to administer over-the-counter medication (Tylenol, Dramamine, Pepto Bismol, and apply sun screen) 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 MILLON LACROSSE CAMP AND Ohio Wesleyan University, 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:** _____

OVER

MEDICAL REPORT
(TO BE COMPLETED BY DOCTOR)

CHILD'S NAME: _____ D/BIRTH: _____

IMMUNIZATIONS:
Include All Dates

DTP	1ST / /	2ND / /	3RD / /	BOOSTER / /	BOOSTER / /
ORAL POLIO	1ST / /	2ND / /	3RD / /	BOOSTER / /	BOOSTER / /
HIB (conjugate)	1ST / /	2ND / /	3RD / /	4TH / /	

Hepatitis B	1st / /	2nd / /	3rd / /
MMR	1st / /	2nd / /	
Other Immunization	Type		Date / /

PHYSICAL EXAMINATION:
(Please Check and Describe Positive Findings)

Height: _____ Weight: _____Skin & Scalp: _____

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

1. Are there allergic Problems? ⇔ Yes ⇔ No
If Yes, specify: _____
2. Is there a special diet required? ⇔ Yes ⇔ No
If Yes, specify: _____
3. Is medication regularly taken? ⇔ Yes ⇔ No
If yes, specify: _____
4. Has your child ever had chicken pox? ⇔ Yes ⇔ No
If yes, specify: _____
5. 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: _____