

MILLON LACROSSE CAMP AND Stony Brook 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 Stony Brook University 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, etc.) and first aid for minor injuries as deemed necessary. I authorize the training staff to supply suntan lotion when needed.

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

Hepatitis B	1 ST / /	2 ND / /	3 RD / /
MMR	1 ST / /	2 ND / /	
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: _____