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)*

Medical	Immunization (include dates)	Allergies
Chicken Pox _____ ☐	Tenanus Toxiod _____	Insect Stings _____ ☐
Diabetes _____ ☐	Tuberculin Test _____	Penicillin _____ ☐
Measles _____ ☐	Measles / Rubella _____	Antibiotics _____ ☐
Asthma _____ ☐	Polio Vaccine _____	
Epilepsy _____ ☐		
Other: _____	Other: _____	Other: _____
_____	_____	_____
_____	_____	_____

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 wavier 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: _____