FRIAR'ed Up Lacrosse Camps

or

Providence Summer Camp Health Form & Waiver & Release Statement

This form must be completed and signed by the camper's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. This form will be returned to you if it is incomplete. Please type or print in black ink.

CAMPER INFORMATION

Camper's Name_____
Permanent Address_____ Date of Birth_____ Sex _____
City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:
Name _____
Relation to camper_____
Daytime Phone _____
Evening Phone _____

Backup contact (relative or friend):
Name_____
Relation to camper _____
Daytime Phone _____
Evening Phone _____

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No
If yes, provide the following information which is required by Duke University Medical Center to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name_____ P.H.'s Date of Birth_____
Address _____ Relation to camper _____
City/State/Zip_____Ocupation_____
P.H.'s Employer_____
Employer's Address_____
Insurance Company_____
Insurance Company's Address_____
Policy #_____Plan #_____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Providence Lacrosse Camp staff to seek medical treatment for the camper as they see necessary at any nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the camper's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the camp staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Camp staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Camp staff will notify me or my designee as soon as possible if any and all diagnoses and treatments are made.

_____ _____ _____
Legal Guardian's Signature Print Name Date

WAIVER & RELEASE STATEMENT

The undersigned, being a parent or legal guardian of the child requesting camp admittance, does hereby affirm that the applicant is in good health, and suffers from no serious illness, disability or condition that requires the taking of medication on a regular basis unless that condition is disclosed and approved. Furthermore, the undersigned has no knowledge of any reason the applicant participate in vigorous physical activity. I understand that, as a condition of admittance as a camper, the undersigned, on behalf of all parents and guardians, and on behalf of the applicant, hereby releases the Friar'ed Up Camp Staff, Providence College, the Providence College Athletic Department, Chris Gabrielli and all other employees or agents of the camp from any liability from any loss or damage or personal property, injury or illness, mental or physical suffered by the camper during or related to camp.

_____ _____ _____
Legal Guardian's Signature Print Name Date

Directions: Completion of this form by a parent or guardian is required before a student can enter camp. Please answer all questions. Incomplete forms will be returned to you for the missing information. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

DOES THE CAMPER CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies:_____
Food allergies:_____
Allergies to insect bites:_____
Special dietary needs:_____
Asthma:_____
Frequent headaches:_____
Dizziness or seizures:_____

LIST: Other health problems:_____
_____

Limitations of Activities:_____
_____

Medications the camper is currently taking:_____
_____
_____

(**Please note**: Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. Yes No
_____
_____

MEDICAL HISTORY

IMMUNIZATION DATES:
Measles_____
Mumps_____
Rubella_____
OR MMR_____
Last Tetanus_____
(DPT, TT, or TD)
Polio Series completes_____

Date of last medical check-up:_____
Reasons for any hospitalization in past 5 years:
_____
_____
_____
_____
_____
_____

PHYSICIAN'S INFORMATION *(to be completed by physician)* Please **PRINT** the following information:
Physician's Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____

I have examined the above named camper and found him to be able to participate in all activities of Providence College Friar'ed Up Lacrosse Camp.

_____ _____ _____
Physician's Signature Print Name Date

FRIAR'ed Up Lacrosse Camp

1 Cunningham Square – Alumni Hall Providence, RI 02918 ▪(p) 401-865-2956 ▪(f) 401-8651231

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PARTICIPANTS
Name_____

Parent/GuardianSignature_____

Date_____