Greg Fargo Hockey, LLC

Medical/Liability Form

Due prior to start of camp

Start Date: _____
End Date: _____

PLEASE COMPLETE ENTIRE FORM!

Camper Name (print) _____
Age at camp ___ **Birth Date:** _____/_____/_____ **Gender:** M F
Address: _____
City_____ **State:** _____ **Zip:** _____
Phone Number (Day): (_____) _____
(Eve): (_____) _____
In Case of Emergency and parent / guardian *cannot* be reached:
Contact: _____**Relationship:** _____
Phone: (_____) _____

Parent/Guardian Authorizations: This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Greg Fargo Hockey, LLC and Colgate University to provide routine healthcare and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the Greg Fargo Hockey, LLC and Colgate University to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of the Colgate Girls Hockey Camps or their designee to secure and administer treatment, including hospitalization, for the student named above.

Indemnification: The undersigned parent/guardian of the registrant, for and in further consideration of Greg Fargo Hockey, LLC and Colgate University's accepting said registrant, hereby agrees to save and indemnify and keep harmless the Greg Fargo Hockey, LLC and Colgate University, the individual members, employees, staff, faculty, agents, representatives, and officers from and against any claims, judgments, or demands which I, any other parent or guardian, the student, or any other person might make for any losses, damages, personal, mental, or physical injuries against any and all liability, arising as a result of any course of instruction or activity given the registrant by Greg Fargo Hockey, LLC or Colgate University. This release and assumption of risk shall bind myself, my heirs, my assigns, and my personal representatives.

Signature of Parent/Guardian _____

Printed Name _____ ***Date*** _____

Medical Insurance Company (REQUIRED)
Ins. Co. _____
Policy # _____**Group #** _____
Insured Employer _____
We recommend that a photocopy (front and back) of health insurance card be attached to this form.

Health History:

Check those that apply:		***Life Threatening Conditions***
❑ Contact Lenses	❑ Ear Aches / Infection	❑ Asthma
❑ Gyn Problems	❑ Poison Ivy, Oak, Sumac	❑ Diabetes
❑ Rheumatic Fever	❑ Stomach Problems	❑ Epilepsy / Seizures
❑ Sore Throat	❑ Absence of a paired organ	❑ Heart Conditions / Murmur
❑ Whooping Cough	❑ Sinus Problems	❑ Food Allergies (specify)
❑ Current orthodontic appliance	❑ Mononucleosis in the past 12 months	❑ Medication Allergies (specify)
❑ Skin Problems (Acne, Eczema)	❑ Recent Illness / Infections	❑ Other Allergies ~ insect stings, hay fever, animal
❑ HBP	❑ Concussion / Head Injury	❑ Other (Please detail)
❑ Bone / Joint Injuries	❑ Other Chronic Condition	
❑ Operations	❑ Other	

*** * * Details of above to be completed on additional sheet * * ***

All Medications (Prescription and Over-the-Counter)

Please complete with the camper's current regimen for both **Prescription and Over-the-Counter** medications (i.e. antibiotics, asthma inhalers, allergies, etc.).

This person takes NO medications on a routine basis.

Drug Name	Route	Dosage	Physician Order / Regimen	Comments

Parent / Guardian's Signature:_____ Date :_____