2019 WSU ATHLETIC

CLINIC / CAMP

Participant Health Form

Please bring this packet FULLY COMPLETED with you to camp registration. Incomplete/unsigned packets will not be accepted.

Participant Name: _____
First Middle Last

Camp Name & Date: _____

☐ Male ☐ Female Birth Date _____ Age on arrival at camp: ____
(Month / Day / Year)

***To Parent(s)/Guardian(s)*: Please keep a copy for your records.**

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal responsibility/authority to be contacted in case of illness or injury, if available:

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____

Additional emergency contact (optional):

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____

Pre-Existing Medical Conditions:

Has the camp participant had, or currently have, any of the following?

Concussions	Y N	Heat Illness	Y N	Surgery	Y N	Current Orthopedic Injury	Y N	Sickle Cell / Trait	Y N
Asthma	Y N	Epilepsy	Y N	Diabetes	Y N	Heart Condition (ie. HCM)	Y N	ADD / ADHD	Y N
Other	Y N								

If you answered 'yes' to any of the above questions please explain in the "General Health Information" section or attach additional information.

Immunizations:

☐ My child is up-to-date on his/her immunizations and tetanus shots as required by participant's home state law.

☐ My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

General Health Information:

NOTE: It is strongly recommended that parents/legal guardians consult a physician prior to allowing their child to participate in physical activity.

Are there any medical concerns which the camp staff should be aware of? ***Attach additional information if needed.***

Allergies: ☐ No known allergies.

This participant is allergic to:

☐ Food ☐Medicine ☐The environment (insect stings, hay fever, etc.) ☐ Other

☐ **This participant has a life-threatening allergy. An emergency care plan signed by physician is required.**

Please describe below, in detail, what the participant is allergic to, the reaction seen, and any preventive or responsive measures utilized (i.e. medications). Attach additional forms if necessary.

Disability:

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

Medication – Day Campers:

Unfortunately, we will be unable to administer medication to children participating in day camps. If your child requires a dosage during camp hours, please make appropriate arrangements. Knowing what your child takes is important should there be a medical emergency situation Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

☐ This participant will not take any daily medications while attending the activities.

Medication – Overnight Campers:

Medication is any substance a person takes to maintain and/or improve their health. This includes all prescription medication, as well as all over-the counter drugs that are potentially hazardous if misused (e.g., Tylenol, aspirin, cough medicine, cold tablets, vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary. Participants are required notify medical staff of any and all medications they have brought with them upon arrival to camp. Participants are responsible for securing all medications and they must not be accessible to other participants.**

☐ This participant will not take any daily medications while attending the activities.

☐ This participant will be **self-administering** the following daily medication(s) while attending the activities **under staff supervision**.[1]

Name of medication	Date started	Reason for Taking	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other time: _____		

Comments:

Health History Verification:

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, risks to your child may increase. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Primary Residential Parent: _____ Date: _____

Parent/Guardian (please print name): _____

Relationship to Participant: _____

Parent/Guardians: Keep a copy for your records.

[1] Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

ASSUMPTION OF RISK

I understand that there are risks in participating in recreational activities and educational workshops at a Washington State University (WSU) Athletic Camp / Clinic.

In consideration for and as a condition of being allowed to participate in this voluntary activity, I agree to take full responsibility for any and all risks that exist, including the risk of death or injury to my child or loss or damage to my property. I understand that there may be risks that WSU cannot predict or foresee, and I also assume full responsibility for those risks.

Risks in participating in a WSU Athletic Camp / Clinic activities, include, but are not limited to: temporary or permanent muscle soreness, sprains, strains, cuts, abrasions, bruises, ligament and/or cartilage damage, orthopedic damage, severe head, brain, neck or spinal injuries, paralysis, loss or use of arms and/or legs, eye damage, disfigurement, or death. I also recognize that there are both foreseeable and unforeseeable risks of injury or death that may occur as a result of traveling to or from a WSU Athletic Camp / Clinic activities that cannot be specifically listed. Further, I recognize that the actions of other participants in the activity may cause harm or loss to my child or property.

EMERGENCY MEDICAL RELEASE

In an emergency requiring medical attention or a situation reasonably believed by Washington State University (WSU) authorized agents including the WSU Athletic Camp / Clinic staff to be an emergency; I authorize WSU and its authorized agents to obtain emergency medical care for my child. I will be responsible for any expenses incurred in so doing including but not limited to care by health care professionals, hospital care, and ambulance or other services. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

I hold harmless and agree to indemnify Washington State University, its authorized agents and employees and the staff of the WSU Athletic Camp / Clinic from decisions to seek emergency treatment

RELEASE OF LIABILITY

I release, the state of Washington, the Regents of WSU, WSU, any subdivision or unit of WSU, its officers, employees, and agents, from any and all liability, claims, costs, expenses, injuries and/or losses to person or property, which I may sustain and/or sustain as a result of death or injury of my child, as a result of or connected with participation in the above event. My child's participation includes, but is not limited to, travel to and from the event in a private or public vehicle, any activity connected with the event itself, and use of state equipment or facilities for the event whether on or off WSU property. **I have carefully read this document, understand its contents and am fully informed about this program and circumstances. I am aware that this document is a contract with WSU and the program sponsors. I sign it freely and voluntarily.**

Signature of Parent / Guardian: _____ **Date:** _____

Parent / Guardian (please print): _____

Witness Signature: _____ **Date:** _____

Witness Name (please print): _____

Washington State University
Athletic Camp / Clinic
Emergency Medical Release

In an emergency requiring medical attention or a situation reasonably believed to be an emergency by Washington State University (WSU) authorized agents including event staff; I authorize WSU and its authorized agents to obtain emergency medical care for my child. I will be responsible for any expenses incurred in so doing including but not limited to care by health care professionals, hospital care, and ambulance or other services. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

NOTE: Minors may consent to certain services in Washington.

I hold harmless and agree to indemnify Washington State University, its authorized agents and employees and the event staff from decisions to seek emergency treatment.

Please complete the following:

Student Participant: _____Date of Birth: _____

Parent or Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ E-mail: _____

<u>Health-Care Providers</u>:

Name of participant's primary doctor(s): _____ Phone:(_____) _____

Name of dentist(s):_____ Phone:(_____) _____

Name of orthodontist(s):_____ Phone:(_____) _____

Additional health care provider(s) name(s) and contact numbers:

_____

_____

Medical Alerts: _____

_____

(severe allergies / life-threatening conditions / chronic illnesses)

Medical Insurance Information:

This participant is covered by family medical and/or hospital insurance ☐ Yes ☐ No

Primary Insurance Company _____

Policy Number _____ Group Number _____

Subscriber _____ Insurance Company Phone Number (_____) _____

Secondary Insurance Company _____

Policy Number _____ Group Number _____

Subscriber _____ Insurance Company Phone Number (_____) _____

Name of another person to contact in case of emergency if you are not available:

_____

Phone: (____) _____ E-mail: _____

Relationship to participant:

_____

I voluntarily sign this authorization in consideration for permission for my child to participate in a WSU Athletic Camp / Clinic. I have read it, and I understand its content and significance.

_____ _____

Signature of Parent/Guardian Date
(For participant less than 18 years of age)

_____ _____

Signature of Participant Date
(For participant 18 years of age or older)

_____ _____

Witness Signature Date