

THE LEADERSHIP ACADEMY FOR GIRLS 2010

Brockport Auxiliary Service Corp. ♦ 350 New Campus Drive ♦ Brockport, NY 14420
Phone: (585) 395 – 2275 ♦ Fax: (585) 395 – 2336 ♦ E-mail: summercamps@brockport.edu

Camper Medical Form

Please complete, SIGN (parent signatures are required) and return this form to:
Camp Medical Director * Brockport Auxiliary Service Corporation *
* 350 New Campus Drive * Brockport NY 14420

PART ONE:

CAMPER INFORMATION:

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ AGE: _____

EMERGENCY CONTACTS:

This is **required** information. MUST have a minimum of three (3) Emergency Contacts. Be sure ALL information is CURRENT and ACCURATE.

1.) Name of Contact: _____ Relationship: _____

Emergency Phone #1: Day-Time: (_____) _____ Evening: (_____) _____
Cell Phone: (_____) _____

2.) Name of Contact: _____ Relationship: _____

Emergency Phone #1: Day-Time: (_____) _____ Evening: (_____) _____
Cell Phone: (_____) _____

3.) Name of Contact: _____ Relationship: _____

Emergency Phone #1: Day-Time: (_____) _____ Evening: (_____) _____
Cell Phone: (_____) _____

INSURANCE INFORMATION:

This is **required** information. Be sure ALL information is CURRENT and ACCURATE.

Name of Medical Insurance Carrier: _____

Name of Insured: _____

Policy/I.D.#: _____

PARENT/GUARDIAN STATEMENT:

I hereby authorize the staff of the Leadership Academy for Girls and/or the medical support staff of Brockport Auxiliary Service Corporation or any area emergency facility to act for me according to their best judgment in any emergency requiring medical attention for my child.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: ____/____/____

PART TWO:

CAMPER MEDICAL HISTORY INFORMATION:

This is required information. Be sure ALL information is CURRENT and ACCURATE.

1. DATES OF IMMUNIZATIONS: (May attach a copy of records from Doctor's Office)

___/___/___ Tetanus Booster	___/___/___ DPT Series	___/___/___ Booster
___/___/___ Measles Vaccine (Live)	___/___/___ Polio OPV	___/___/___ Booster
___/___/___ German Measles (Rubella)	___/___/___ TB Test & Result	
___/___/___ Mumps Vaccine (Live)		

2. NORMAL PULSE RATE: _____ NORMAL BLOOD PRESSURE: _____

3. ALLERGIES:

To What?:	Reaction:	Medication?:
_____	_____	_____
_____	_____	_____

4. LIST ANY MUSCULAR-SKELETAL INJURIES OR DISEASES. LIST NECESSARY TREATMENT PROCEDURES:

5. MEDICATIONS:
PLEASE NOTE – If your child will need any form of medication during their stay you MUST provide the medication in the original PRESCRIPTION bottle. If medication is brought in any container other than the original, you will be required to submit a detailed written letter describing the medication, purpose, dosage, timing, and a signed statement that you take FULL responsibility for any problems arising from a lack of proper documentation.

I have read the above statement and fully understand. Parent/Guardian Signature: _____

List ALL medications Camper will be taking during stay (prescriptions, inhalers, aspirin, vitamins, etc.):

NAME:	DOSAGE:	HOW OFTEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does Camper administer own medication? _____ YES _____ NO

6. DIETARY INFORMATION:
Does Camper have any special dietary requirements? _____ YES _____ NO
If YES, please explain on lines provided below.

7. List any information that may assist the Medical Director, physician or nurse in caring for your child:

This form must be completed in full and submitted prior to the start of camp. If the Camp Medical Director does not receive a COMPLETED Medical Form for your child, your child will NOT be able to attend camp. If you have any questions please call: (585) 395-2275. There are NO exceptions.

8. DOCTOR INFORMATION:

Was a physical necessary to complete the information on this form? _____ YES _____ NO

If YES, please have the Doctor sign the Physician's Statement:

I find the above named camper eligible to participate in The Leadership Academy programs and activities.

SIGNATURE OF PHYSICIAN: _____ DATE: ____/____/____

PLEASE PRINT YOUR CHILD'S DOCTOR'S NAME, PHONE, AND FULL ADDRESS:

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OFFICE PHONE: (____) ____ - _____ EMERGENCY PHONE: (____) ____ - _____

PART THREE:

REQUIRED

AGREEMENT TO INDEMNIFY AND SAVE HARMLESS

I/we agree to indemnify and save harmless the State of New York, the State University of New York, the State University College at Brockport, Leadership Academy for Girls, and all its officers and employees from any and all claims, demands, suits, judgments, costs, expenses, actions, and causes of action for personal injury or injuries, death or loss or damage(s) to property sustained by the undersigned participant in the Leadership Academy for Girls, sponsored by Brockport Auxiliary Services Corporation, at the State University of New York College at Brockport from July 18th, 2010 through July 24th, 2010, or arising out of any travel to or from, and/or the campus and/or other premises, of the State of New York, the State University of New York, and/or the State University College at Brockport, with particular respect to the Leadership Academy for Girls, sponsored by Brockport Auxiliary Services Corporation.

Signature of Participant

Date

_____/_____/_____
Birthdate of Participant

Age

If the participant has not yet attained the age of 18, both parents and/or participant's legal guardians MUST also sign and date this form.

Signature of Participant's Father or Legal Guardian

Date

Signature of Participant's Mother or Legal Guardian

Date

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