

MEDICAL WAIVER FORM

This form **MUST** be completed and returned to 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

CAMPER'S NAME: _____ DOB: ____/____/____ AGE: ____

CAMPER ADDRESS: _____

EMERGENCY CONTACT

CONTACT #1

NAME: _____

PHONE #: _____

CELL PHONE #: _____

EMAIL: _____

CONTACT #2

NAME: _____

PHONE #: _____

CELL PHONE #: _____

EMAIL: _____

MEDICAL INFORMATION

PHYSICIAN'S NAME: _____ PHONE #: _____

ADDRESS/CITY/STATE/ZIP: _____

(Please circle)

Is participant under the care of a provider for a medical condition? NO / YES

Is participant taking medication prescribed by a healthcare provider? NO / YES

-If YES, please explain further: _____

***University of Maryland Women's Lacrosse camp trainers and staff are unable to administer medication of any kind. If medication is needed, a parent/guardian must be on site to administer.**

ALLERGIES:

Insect Stings <input type="checkbox"/> NO / <input type="checkbox"/> YES	Food <input type="checkbox"/> NO / <input type="checkbox"/> YES	Medications <input type="checkbox"/> NO / <input type="checkbox"/> YES	Do you use an EpiPen? <input type="checkbox"/> NO / <input type="checkbox"/> YES
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If YES, please explain further: _____

Are there any medical conditions that require special attention (*ex: asthmas, epilepsy, diabetes, etc.*)? If so, please explain further: _____

INSURANCE INFORMATION

INSURANCE CARRIER: _____ POLICY #: _____

POLICY HOLDER NAME: _____ GROUP #: _____

LIABILITY WAIVER

*The undersigned, being a parent or legal guardian of this camper understands and accepts that injury is possible while participating in the sport of lacrosse. I knowingly assume all risks associated with my child's participation, even if arising from negligence of the participants or others, and assume FULL responsibility for my child's participation.

*I authorize that sport camp staff to secure the proper medical care as necessary to insure my child's well-being.

*I certify that within the past 12 months my child has had a physical exam by a physician or NP and that he/she is physically able to participate in the sports camp activities.

*I hereby acknowledge that I am responsible for medical charges incurred during sports camp participation. I further understand that the sports camp carries an excess medical insurance policy for sports injuries to the camper that may result from camper activities. Camp insurance has limits and exclusions and any secondary charges not covered under this plan will be my responsibility. This policy may only be utilized after my primary insurance company has processed the claims and issued an explanation of benefits.

*I also give permission for the camp directors to take pictures of the camper to use for further promotions of University of Maryland Camps and Clinics.

My signature below indicates that I have read and understand these terms:

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

RELATIONSHIP to PARTICIPANT: _____