

Camp: \_\_\_\_\_

Dates: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

**As the parent or legal guardian of the minor child named below (“Participant”), I understand that** the information requested on this form is intended to help inform program staff of any pre-existing medical conditions. If Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. ***This information will be kept in strict confidence and will only be shared with your permission.*** Auburn University requests the information below so that, in case of emergency, we will have accurate information to provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medical history. **Final determination about whether to participate is the responsibility of you and your physician.**

### **GENERAL INFORMATION**

Parent/Legal Guardian Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

#### **EMERGENCY CONTACTS**

Emergency Contact #1 Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact #2 Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **MEDICAL INFORMATION**

It is required that Participant consult with a physician prior to participating in this Program and provide proof of clearance to participate by a valid medical physical completed within 12 months of camp conclusion. If you are uncertain about any preexisting medical conditions, ***it is your responsibility to consult with your own physician*** prior to participating in this Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. If Participant has any medical issue that is not requested below, but which you think is important, please include that information. Use the back and/or additional space if needed.

Although immunizations are not required for participation, we strongly encourage that program participants are appropriately immunized for, at minimum, the following diseases: tetanus, measles, mumps, rubella (MMR), meningococcal meningitis.

Date of most recent tetanus toxoid immunization: \_\_\_\_\_

\_\_\_\_\_ (please initial) I understand and acknowledge that because immunizations are not required, program participants may be exposed to individuals who have not been immunized and/or individuals who may carry infectious diseases, which may result in Participant contracting an infectious disease.

\_\_\_\_\_ (please initial) I understand and accept the risks to Participant that relate to and arise from potential exposure to and contraction of an infectious disease including but not limited to COVID-19. I freely and fully accept these risks. I accept the personal responsibility of prevention as well as any physical or financial responsibilities that result from participation.

\_\_\_\_\_ (please initial) I understand, acknowledge, and accept all participation protocols, policies, and practices of both the event and any governing agencies affecting the event. I understand and accept that program/event policies may change without warning, as necessity, governance, and safety require. I will maintain active awareness of possible changes.

Participant name: \_\_\_\_\_

**MEDICAL CLEARANCE**

To be submitted a minimum of two weeks prior to clinic to: [strauks@auburn.edu](mailto:strauks@auburn.edu)  
[must be signed by physician]

Note: attaching a valid pre participation physical to this document may serve in the place of the physical signature by denoting "physical attached" on the physician signature line AND attaching a copy of a valid physical completed within 12 months of camp conclusion. Please provide name and contact of physician as indicated if using this option.

I, \_\_\_\_\_, hereby certify that the named participant is physically able to participate in Auburn University Sports Camps and that I know of no physical impairments which would in any manner limit his/her participation in such camp.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Name (PRINT)

\_\_\_\_\_  
Contact Phone Number

**MEDICAL INSURANCE INFORMATION**

Insurance Provider: \_\_\_\_\_ Insurance subscriber name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Subscriber date of birth: \_\_\_\_\_

Ins. Co. Phone Number: \_\_\_\_\_ Ins. Co. Address: \_\_\_\_\_

**For the following, indicate the response and explain as appropriate:**

**Does participant have any limiting medical conditions that you or your doctor feel would limit participation in the Program?**  
YES      NO

If yes, identify and explain: \_\_\_\_\_

**Is Participant currently taking medication that may interfere with their ability to safely participate?** YES      NO

If yes, please indicate the medication and the condition being treated: \_\_\_\_\_

**Does Participant have a history of ANY allergies or reactions to medications, latex, insect stings, plants, etc.?** YES      NO

If yes, please explain: \_\_\_\_\_

**Does participant have a history of, or currently suffer from, ANY medical condition(s) of which we need to be aware?**

YES      NO

If yes, please explain:

**Will your child need to take medication(s) during the program?** YES      NO

**FOOD ALLERGY/INTOLERANCE/OTHER DIETARY CONCERN**

**Does your child have a food allergy, food intolerance, or other dietary concern?** YES      NO

Please provide any additional information or explanation that you feel could be relevant or beneficial for our staff to know in supporting your child during this program. (Attach additional information, if necessary.)

Participant name: \_\_\_\_\_

## PARENTAL / GUARDIAN CONSENT AND WAIVER OR RESPONSIBILITY

In consideration of the Auburn University Sports Camp acceptance of \_\_\_\_\_ as a participant in sports camp for the period of time in the dates mentioned above.

It is agreed that all risks inherent to watching and/or participating in camp activities including but not limited to bodily injury, are assumed by the participant and his/her parent and/or legal guardian and that this assumption is acknowledged, approved, and agreed to by the participant and his/her parents and/or legal guardian as indicated by their signature hereto. Sports camp insurance will be financially responsible for injuries/accidents occurring during camp, only as secondary coverage after the parent's/guardian's insurance has paid. **It is required that the participant have a valid/active primary medical insurance policy with appropriate benefits for any injury/illness** sustained by participating in camp activities. The policy must be provided to the camp staff or medical professionals prior to camp activities and upon request.

In cases where medical attention is necessary, parents/guardians will be contacted for approval when possible. However, before medical treatment can be provided, we are required to have a medical release signed by the parent/ guardian. Participant has my permission to receive medical attention in the event of illness or medical emergency while participating in this Program. I will assume the financial responsibility for any cost of health care for Participant that may occur during this Program, including any costs of transportation to receive medical attention.

As a Participant, parent, or guardian, I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name I represent and warrant that I have provided all materials and important information to Auburn University pertaining to Participant's medical, mental, and physical condition and that it is accurate and complete. I agree to notify Auburn University of any changes in Participant's medical, mental, or physical condition prior to the Program. I understand that by revealing or disclosing the above medical information it will not be used by Auburn University personnel or employees to determine Participant's ability to participate safely in activities.

I understand that if Participant chooses to participate in activities, they do so voluntarily and of their own accord and the final decision regarding participation is solely the responsibility of myself and Participant. I hereby hold harmless and agree to indemnify the Youth Program, Youth Program Personnel, Auburn University; its Board of Trustees, individually and collectively; Administrators; Faculty; Staff; and all other officers, directors, employees, and agents against any claims that may arise relating to Participant's medical care while participating in this Program.

\_\_\_\_\_  
Participant name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Signature(s)

\_\_\_\_\_  
Parent or legal guardian Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or legal guardian Signature(s)

***A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 19***