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/necessary items. 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/as needed for appropriate management.*** 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 and all correct information. **Final determination about whether to participate is the responsibility of you and your physician. Camp Staff may limit/alter participation for safety reasons at any time as deemed appropriate.**

GENERAL INFORMATION

Parent/Legal Guardian Name: ____

Street Address: ____City: ________________State:____ Zip:___

Email: ____Cell Phone:______________________________

EMERGECNY CONTACTS (should be different than above)

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

I 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 with all recommended immunizations and, 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, 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 uploaded to campnetwork a minimum of two weeks prior to clinic to: strauks@auburn.edu

[must be signed by physician/physician designee]

*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 of exam

____ **Physician's Name (PRINT)**

___________________________ Contact Phone Number

MEDICAL INSURANCE INFORMATION

A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD ID REQUIRED WITH THIS FORM.

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 Please list:_____________________________

Staff will not hold or dispense medications to participants; each participant must be able to manage. (Parent acknowledgement) _____

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.)

DISABILITY INFORMATION

Does your child have a disability that requires accommodations to enable them to participate in the Program? YES NO
_________(please initial) If accommodations are requested, I give Auburn University permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include sharing information with appropriate University personnel, and I acknowledge that such communication is consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

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 indemnity 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