GUARDIAN CONSENT LETTER FOR TRAVEL & EMERGENCY

To Whom It May Concern:

This is to confirm that my child, __________________________, will participate in one or more NUSEA events in the 2014-2015 program year (September 1, 2014 – August 31, 2015) and will be under the supervision of NUSEA's coaches, staff members and volunteers.

In the event of an emergency, I grant permission and do authorize NUSEA coaches, staff members and volunteers to make any necessary decisions regarding my child's welfare and medical condition. Should there be any need, I can be contacted at the phone number(s) listed below.

Sincerely,

_______________________________ Date: _____________ ____________________________________
(Signature of Parent/Guardian) (Print name of Parent/Guardian)

Phone (h) _______________________ Phone (w) _____________________ Phone (c) ____________________

Additional Parent/Guardian Cell ____________________ If parents/guardian cannot be reached, please contact:

Non-Parent Contact: ______________________________________ Phone: ______________________________

Health Insurance Company or Policy Name: _______________________________

Policy/ID #: ___________________________ Group #___________________________________

Does your child have allergies or regularly take medication? If yes, please describe:

____

Does your child have permission to swim during NUSEA activities? **YES** **NO**

Can your child swim in the deep end of a pool? **YES** **NO**

WAIVER AND RELEASE OF LIABILITY AGREEMENT

IN CONSIDERATION of my involvement with a NUSEA event, I acknowledge, appreciate and agree that:

1. I risk bodily injury, including paralysis, dismemberment and disability, and while particular rules of the sport, equipment, and discipline may reduce this risk, this risk of injury does exist, as well as the risk of damage to or loss of property; and

2. I knowingly and freely assume all such risks, even if arising from the negligence of the releases or others; and

3. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual or unnecessary hazard during my presence or participation or if I observe any concern in my readiness for participation, I will immediately bring such to the attention of the nearest official and refrain from participation; and

4. I, for myself, and on behalf of my heirs, assigns, personal representatives, and next of kin, hereby release, hold harmless, and promise not to sue NUSEA or other sponsoring organization, their officers, volunteers, staff, sponsors and/or agents, ("Releasees") with respect to any and all injury and loss arising from my participation, whether caused by the negligence of the Releasees or otherwise, except that which is the result of gross negligence or wanton misconduct, to the fullest extent permitted by law.

I have read this Waiver and Release of Liability Agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement.

Participant's Signature ________________________________ Date ___________

Participant's Name (Printed)_________________________________

FOR PARTICIPANTS OF MINORITY AGE
This is to certify that I/we as parent(s)/guardian(s) with legal responsibility for this participant, do consent and agree not only to his/her release, but also for myself/ourselves, and my/our heirs, assigns and next of kin to release and indemnify the Releasees from any and all Liability incident to my/our minor child's involvement as stated above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES, to the fullest extent permitted by law.

Parent or Legal Guardian Signature ______________________________ Date ___________

HEALTH FORM

Camper's Name ____________________________ Session ________ Home Phone _______________

Street Address/Town _______________________________________ Date of Birth _______________

Parent/Guardian Name(s) ____

Students are required to be immunized with the following. Please list specific dates for all immunizations or attach a form from the physician with this information.

Diphtheria, Tetanus, Pertussis (DTaP/DTP/DT/Td) (4): ________ ________ ________ ________

Td or Tdap (preferred) Grade 7 thru College (1) ______

Everyone else is required to have a dose of Td (Tdap preferred) if it has been more than 10 years since the previous dose of Td.

Polio (OPV/e-IPV) (3):________ ________ ________ Tetanus/diphtheria (td) Booster: __________

MMR (1): ______ Measles: (2nd dose req'd) ______

Hepatitis B (3): ________ ________ ________ OR Laboratory evidence of immunity

Chicken pox/Varicella vaccine ______ (1 dose recommended 11-17 yrs old / 2 doses req'd for 7th graders and college freshman / Phase in beginning Fall 2011) – OR – healthcare provider certified history of chickenpox disease.

Date of last complete physical exam:_________________ Height___________ Weight__________

Blood Pressure:_______/_______ Hct. or Hgb.:_______ TB test_______

Any significant illness or injuries since last physical exam? _________________________________

General estimate of health:____

Medication or treatment orders to be carried out at camp:

____

Please list allergies, required medications, health conditions which may affect camper's activities: ____

Name and address of health care provider:____

____ Health care provider phone:__________________

Signature of examining physician/nurse practitioner:___________________________________

NATIONAL URBAN SQUASH
+ EDUCATION ASSOCIATION

Authorization for the Administration of Medication by Program Personnel

Parents/guardians requesting medication administration to their child from camp staff shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child ____________________________ Date of Birth ____/____/____Today's Date ____/____/____

Medication Name ____ Controlled Drug? YES NO

Dosage ____________________ Method _________________ Time of Administration _____________________

Specific Instructions for Medication Administration ____

Medication Administration: Start Date _____/_____/_____ Stop Date _____/_____/_____

Relevant Side Effects of Medication ____

Plan of Management for Side Effects ____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain ____

Prescriber's Name_______________________________________ Phone Number (_____) _________________

Prescriber's Address ____ Town _______________________

Prescriber's Signature ____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of Camp ____ Today's Date ______/_____/_____

Child's Name _______________________ Address _____________________________ Town______________

Name of Parent/Guardian Authorizing Administration of Medication ___________________________________

Relationship to Child: Mother Father Guardian/Other explain: ______________________________

Address _______________________________ Town ______________Phone Number (_____) ___________

Signature of Parent/Guardian Authorizing Administration of Medication _______________________________

Name of Camp Personnel Receiving Written Authorization and Medication [FOR PROGRAM USE]

______________________________________ ______________________________________

Title/Position Signature