NATIONAL URBAN SQUASH
+ EDUCATION ASSOCIATION

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 2015-2016 program year (September 1, 2015 – August 31, 2016) and will be under the supervision of NUSEA's coaches, staff members and volunteers. I authorize NUSEA to take photos and videos of my child during these events, and to use my child's image in print or electronically for any lawful purpose such as newsletters and website content. 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)

Parent/Guardian 1 Name: _____

Phone (h) _____ Phone (w) _____ Phone (c) _____

Parent/Guardian 2 Name: _____

Phone (h) _____ Phone (w) _____ Phone (c) _____

If parents/guardian cannot be reached, please contact:

Name: _____Phone: _____

Student Cell Phone: _____

Student Date of Birth: _____ (MM/DD/YY)

Health Insurance Company or Policy Name: _____

Policy/ID #: _____ Group #_____

Does your child have allergies or regularly take medication? **YES** **NO**

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**

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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 _____

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HEALTH FORM

Student Full Name _____ 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:_____ *(must be within 24 months of NUSEA event)*

Height_____ Weight_____ Blood Pressure:_____/_____ Hct. or Hgb.:_____ TB test_____

Any significant illness or injuries since last physical exam? _____

General estimate of health:_____

Please list medication or treatment orders to be carried out at camp:

_____

Please list allergies, health conditions such as asthma, etc., which may affect student's activities:

_____

Name and address of health care provider:_____

_____ Health care provider phone:_____

Signature of examining physician/nurse practitioner:_____

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Authorization for the Administration of Medication by Program Personnel

Parents/guardians requesting medication administration to their child from camp staff shall provide the appropriate written authorization(s) before any medications are administered. Medication prescribed for students shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescription or required by law, and if tablets or capsules, the number in the container. All over-the-counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

Participants may only take medication when it is administered by the health supervisor or a licensed health care professional. All unused medication will be destroyed if not picked up within one week following camper's departure.

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 _____

Expiration date of Medications Received _____ Special Storage Requirements_____

Specific Instructions for Medication Administration: _____

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

Specific Precautions: _____

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 _____

Diagnosis (at parents' discretion)_____

Name of Licensed Prescriber_____ Phone Number (_____) _____

Licensed Prescriber's Address _____

Parent/Guardian Authorization:

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

Name of NUSEA Activity/Event _____ Dates of Event: _____

Child's Address _____ City, State _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child (circle): 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	Printed Name
_____	_____
Signature	Date