SQUASH + EDUCATION ALLIANCE

2017-18 STUDENT INFORMATION

Student name: _____ **Sex:** _____ **Date of birth:** _____

Student cell phone: _____ **SEA member program:** _____

☐ No student cell phone

Parent/Guardian 1 name: _____

Relationship: _____
Cell phone #: _____
Home phone #: _____
Work phone #: _____
Email: _____

Parent/Guardian 2 name: _____

Relationship: _____
Cell phone #: _____
Home phone #: _____
Work phone #: _____
Email: _____

Home address: _____
Street & Apt City, State Zip Code

Emergency contact: If parents/guardian cannot be reached, please contact:

Name: _____ Relationship: _____ Phone: _____

Primary health care provider (doctor's name)**:** _____

Name of clinic/office: _____ Phone number: _____

Address: _____
Street & Apt City, State Zip Code

Health insurance company or policy name: _____ ☐ No insurance

Policy/ID #: _____ Group #: _____

Does your child have **allergies**? **YES** **NO**

If yes, please describe: _____

Does your child have **any medical conditions** and/or regularly take **medication**? **YES** **NO**

If yes, please describe: _____

** Please note that **if your child needs to take medication at camp**, you must:

- ❑ Provide written authorization for SEA to administer medication to your child
- ❑ Send the medication in the original container

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CONSENT FOR PARTICIPATION AND MEDICAL TREATMENT

I confirm that my child, named above, will participate in one or more SEA events in the 2017-2018 program year (September 1, 2017 – August 31, 2018) and will be under the supervision of SEA and its member program coaches, staff members and volunteers. In the event of an emergency, I grant permission and do authorize SEA 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 above.

➤ **Parent/Legal Guardian Signature** _____ **Date**_____

WAIVER AND RELEASE OF LIABILITY AGREEMENT

IN CONSIDERATION of my or my child's involvement with a SEA 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 and/or loss of property; and
2. I knowingly and freely assume all such risks, even if arising from the negligence of the releasees of 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 SEA or other sponsoring organization(s), 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; and
5. I authorize SEA to take photos and videos of me or my child during these events, and to use my or my child's image in print or electronically for any lawful purpose such as newsletters and website content.

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 (Student) Signature** _____ **Date** _____

FOR PARTICIPANTS OF MINORITY AGE

This is to certify that I as a parent/guardian 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/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) (5): _____ _____ _____ _____ _____

Td/Tdap for grade 7 (age 12) thru college* (1): _____ Tetanus/diphtheria (td) Booster: _____
** Everyone else is required to have a dose of Tdap/Td if it has been more than 10 years since the previous dose of Td.*

Polio (OPV/e-IPV) (4):_____ _____ _____ _____
3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose.

MMR (2): _____ _____OR Laboratory evidence of immunity

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

Varicella vaccine (2): _____ _____ OR – healthcare provider certified history of chickenpox disease.

Date of last complete physical exam:_____ *(must be within 18 months of SEA 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 filing, 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]

_____ _____ _____

Name & Title/Position Signature Date

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