2019 Penn Squash Camp

PARENTAL RELEASE FORM

This form must be completed in FULL, including signature of Parent or Guardian, and brought to first day of camp or emailed to fglane@upenn.edu. *Campers will not be allowed to participate without both the Parental Release and Health Form completed in full.*

Camper's Name:

_____

EMERGENCY CONTACT INFORMATION

Print Emergency Contacts and Phone Numbers:

1. Name:_____ Relation: _____

Phone Number (____)_____ Home/Work/Cell?

Phone Number (____)_____ Home/Work/Cell?

Email:_____

2. Name:_____ Relation: _____

Phone Number (____)_____ Home/Work/Cell?

Phone Number (____)_____ Home/Work/Cell?

Email:_____

HEALTH INSURANCE

Health Insurance Provider _____

Policy/Plan Number _____

Address of insurance company_____

Phone # of insurance company_____

Name of subscriber to the policy or plan: _____

Relation to athlete_____

I, _____ agree to accept full financial responsibility for necessary medical treatment for _____ while at the Penn Squash Camp at the University of Pennsylvania.

Print name: _____ Date: _____

Signature: _____ ( ) Parent ( ) Guardian

HEALTH FORM

This form must be completed in FULL, including signature of a physician, and brought to the first day of camp or emailed to fglane@upenn.edu.
A copy of a camper's school physical, including immunization history and a doctor's signature, may be substituted in lieu of this form if the physical was performed within 12 months prior to the camp start date. Campers will not be allowed to participate without both Parental Release and Health form completed in full.

Camp Name: _____ Date of camp: _____

Camper's Name: _____ Sex: _____ Age: _____
(Last Name) **(First Name)**

Height: _____ Weight: _____

Medical History (please check for "yes")

German Measles ☐ Measles ☐ Mumps ☐ Scarlet Fever ☐
Chicken Pox ☐
Diabetes ☐ Pneumonia ☐ Other: _____

Immunization History	**Mo./Yr.**	**Allergy History**	**Yes**	**No**	**Drug Reactions**	**Yes**	**No**
Diphtheria	_____	Hay Fever	☐	☐	Sulpha	☐	☐
Tetanus Toxoid	_____	Asthma	☐	☐	Penicillin	☐	☐
Polio Vaccine	_____	Eczema	☐	☐	Antibiotic	☐	☐
Tuberculin Test	_____	Hives	☐	☐	Type:_____		
Measles	_____	Insect Stings	☐	☐			

If medication will be taken during camp, indicate name of drug and dosage:

_____

Please list any pertinent medical information we should have regarding past injuries, past medical history, or suggested physical limitations relating directly to the participant's ability to participate in the camp for six or more hours per day:

_____

(Attach additional sheets if necessary)

I certify the above-named individual is able to participate fully in the above-named activity, based on physical examination within 12 months prior to said camp date.

_____ _____
(Signature of Physician) **(Date)**

_____ _____ _____ _____
(Street Address) **(City)** **(State)** **(Zip)**