MEDICAL TREATMENT AUTHORIZATION

I, ______________________________, do hereby appoint and authorize Colorado Christian University, Colorado Christian University Athletics and its designated staff as my representative to obtain and consent to any and all medical/dental attention and hospital care and treatment, including major surgery deemed necessary by an appropriate medical/dental provider selected by me representatives for the health and well-being of my daughter ____, who is attending the with Colorado Christian University Athletics. By nature, athletic participation includes a risk of injury which may range in severity from minor to long-term catastrophic, sometimes resulting in death. Although serious injuries are not common in supervised school athletic programs, it is possible to reduce this risk. Participants must obey all safety rules, report all physical problems to their coaches, and inspect their own equipment daily. Colorado Christian University and The Colorado Christian University Athletics does not screen applicant for illness, injury, allergies, or other medical conditions which would prevent or limit participation by the applicant in athletics or outdoor programs. By signing this form, I acknowledge that I do not know of any medical condition which would prevent or limit the participation of this applicant in athletics or outdoor programs. I, on my own behalf and on behalf of this applicant, hereby release Colorado Christian University and Colorado Christian University Athletics, its employees agents, and representatives from any financial responsibility or liability arising from injury to this applicant in connection with his or her participation in the summer sessions, including injury resulting from negligence (other than gross negligence) of employees, agents or other representative of Colorado Christian University Athletics. Colorado Christian University Athletics and Colorado Christian University are not fully equipped to meet the needs of individuals with special needs and disabilities.

Parent or Legal Guardian ____

Address ____

City, State, Zip ____

Home Phone ____

Work Phone ____

Please note: Our staff cannot administer any medications, prescription, or otherwise, to campers. This includes over-the-counter medications like Advil or Tylenol for minor headaches or pains. If the camper will need to take medication while attending our camp, he or she must bring the medication to camp and assume responsibility for taking it as needed.

Medical History and Emergency Information

This form must be completed and signed by the camper's parent or legal guardian. This form will be returned if not complete. Please print clearly and return to:

Colorado Christian University
Basketball
Corey Laster
8787 West Alameda Ave
Lakewood, CO 80226
claster@ccu.edu

Camper Info: SS#:

Date of Birth: Permanent Address:

City, State, Zip Home Phone:

<u>Medical emergency contact info:</u>

Person to contact:

Relation to camper:

Daytime phone:

Evening phone:

Secondary Backup Contact:

Relation to camper:

Daytime phone:

Evening phone:

<u>Insurance Policy Info:</u>

The above named child is covered by health insurance: yes/ no (circle)

If yes, please provide the following info:

Policy holders' name:

Date of Birth

Address:

City, state, zip:

Relation to camper:

Occupation:

Policy Holders employer:

Insurance Company:

Insurance company's address:

Policy #:

Plan:

Permission to Treat & Medical Release Check ONE of the following and sign below:

____In the event of illness or injury, I understand that every attempt will be made to contact me before medical action is taken. However, in the event of an emergency, I hereby grant my consent for medical treatments and permissions for the attending physician or appropriate medical personnel, to hospitalize, secure proper treatment and/or injections, anesthesia, or surgery. I will be responsible for any medical or other charges connected with my child's attendance at the camp.

____I DO NOT want any type of medical treatment provided to my child.

________________________________ __________________________________ Parent/Guardian Name
Parent/Guardian Signature

Date:

Directions: To be completed by legal guardian. Please answer all questions. Incomplete forms will be returned. Please print clearly and attach any specific recommendation from your physician to this form

Does this camper have any of the following? (If yes, please describe)

Description Drug allergies? No/Yes

Food allergies? No/Yes

Allergies to insects? No/Yes

Special dietary needs? No/yes

Asthma? No/yes

Frequent headaches? No/yes

Dizziness or seizures? No/yes

Other health problems:

Is this camper currently taking medications? No/yes.

If yes, what?

Will your child require any specific treatments for a medical/emotional condition while participating in our camp? No/ yes

If yes, please describe?

Medical History: (up to date?)

Immunization dates: Measles______ Mumps______ Rubella ______ MMR (combined) Last Tetanus_______ Polio Series_____ Date of last check-up_________

Reasons for any hospitalization in the past 5 years? No/Yes.

If yes, please describe….

Physicians Name:

Address:

Phone: