

# PRINCETON

## SPORTS CAMPS

### ***PARENTAL RELEASE FORM***

*This form must be completed in FULL, including signature of Parent or Guardian, and brought to check-in. Faxed or mailed copies will not be accepted. Campers will not be allowed to participate without both the Parental Release and Health Forms completed in full.*

Camper's Name: \_\_\_\_\_

Emergency Contact Name and Number: \_\_\_\_\_

I, \_\_\_\_\_, give permission for \_\_\_\_\_ to  
(Parent or Guardian) (name of camper)

attend and participate in the Princeton University \_\_\_\_\_  
(name of camp) (dates of camp)

I authorize the staff of the camp to use their best judgment in allowing my child to receive emergency medical or surgical treatment if necessary. I understand that every effort will be made to contact me prior to such action.

**(PLEASE BE ADVISED THAT IT IS IMPERATIVE THAT YOUR CHILD BE IN GOOD HEALTH WHEN ARRIVING AT CAMP. THE DUTIES OF CAMP PERSONNEL CANNOT INCLUDE PROVIDING MEDICAL CARE.)**

I hereby:

1. certify that, to the best of my knowledge, the medical information is complete and correct.
2. agree to assume all risk of personal injury arising from participation in this camp, understanding that this sport does involve the potential for injury.
3. agree not to hold the staff responsible for any injury sustained during camp participation.
4. agree not to make any claims or demands against camp staff or Princeton University for any injury sustained.
5. agree to allow the Camp Director to use his/her judgment in obtaining necessary medical care, at the expense of the parent.
6. agree to accept any decisions made by the Camp Director in terminating attendance due to unacceptable behavior.

I can be reached by phone during the day at: \_\_\_\_\_ and in the evening at:

\_\_\_\_\_.

An alternative/emergency contact person is: \_\_\_\_\_ and can

be reached by phone at: (DAY) \_\_\_\_\_, (EVE.) \_\_\_\_\_.

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent)

\_\_\_\_\_  
(Date)

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## SPORTS CAMPS

### HEALTH FORM

*This form must be completed in FULL, including signature of a physician, and brought to check-in. Faxed or mailed copies will not be accepted. 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 forms 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

#### Allergy History

#### Drug Reactions

	Mo./Yr.		Yes	No		Yes	No
Small Pox Vaccine	_____	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sulpha	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus Toxoid	_____	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
Polio Vaccine	_____	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____		
Tuberculin Test	_____	Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Measles	_____				_____		

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)