

EMERGENCY HEALTH FORM (confidential)
PLEASE DO **NOT** SEND VIA MAIL – BRING TO CHECK IN

FRIAR LACROSSE CAMPS, LLC

Applicant's Social Security no. _____ Age _____

Last name _____ First name _____ Middle initial _____

Home phone _____ email address _____

Home address – street number and name _____

City _____ State _____ ZIP code _____

Mother's/guardian's daytime phone _____ Home phone _____ Cell Phone _____

Father's/guardian's daytime phone _____ Home phone _____ Cell Phone _____

MEDICAL TREATMENT AUTHORIZATION

I understand that the consent and authorization herein granted do not include major surgical procedures and are valid only during the camp. Physical conditions that the clinician should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, etc.):

_____. Date of most recent tetanus immunization: ____/____/____

(If more than ten years ago, a booster shot is recommended.) In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency, and if I cannot be reached, I give my consent for **FRIAR LACROSSE CAMPS, LLC** to bring my child to the nearest emergency medical facility to perform any necessary emergency treatment. I am aware that the camp's medical insurance will cover only those costs that my own insurance does not cover.

PERMISSION TO PARTICIPATE

I individually and as the father/mother/or legal guardian, do hereby give my permission to my son to participate in the **Friar Lacrosse Camp** and use the facilities of **Providence College** in connection with the camp program. In consideration of your enrolling my son in the program, I agree to indemnify and hold harmless, **Providence College, Friar Lacrosse Camps, LLC** and all officers, trustees, agents and employees of above mentioned organizations from all claims, liability, loss and damage and expense which may in any way arise from my son's participation in the **Friar Lacrosse Camp**, including without limitation, all claims which my son, his parents/guardian may have for personal injuries to other persons which are caused by my son. To the best of my knowledge and belief, my son is of sound health and I know of no reason why he cannot participate in the program offered by **Friar Lacrosse Camps, LLC**.

Name of emergency contact _____ Phone _____

Name of family physician _____ Phone _____

Parent's or guardian's name (please print) _____

Signature _____ Date _____

Please indicate (if applicable) HMO PPO

Insurance company - address – street number and name _____

City _____ State _____ ZIP code _____

Policy subscriber's name _____ Policy no. _____ Group no. _____

PLEASE ATTACH PHOTO COPY OF INSURANCE CARD – FRONT AND BACK