

EMERGENCY HEALTH FORM-PERMISSION FORM

24 Lacrosse, LLC

PLEASE FAX THIS FORM AND A PHOTO COPY OF FRONT AND BACK OF HELATH INSURANCE FORM TO 401-865-1231
Please indicate which camp you will be attending (circle one)

Camp name _____

Player Last name _____ First name _____ Middle initial _____ Age _____

Home phone _____ Parent email address _____ Player 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

In anticipation of my child's participation in the camp program, I certify that I have consulted with my child's physician and that my child has been medically cleared for camp-related activity. I agree that I am financially responsible for any and all medical expenses associated with my child's participation in this program. I understand that my child will not be allowed to participate in this program without medical insurance coverage as documented below. 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 **24 LACROSSE, 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.

Signature _____

Date _____

PERMISSION TO PARTICIPATE

I, the camper's parent/legal guardian, understand the nature of camp activities, certify that the camper is able to participate in the program, and grant permission for said participation. On behalf of myself, my child, and our assigns, executors and heirs, I hereby release, discharge, covenant not to sue, and agree to indemnify and hold harmless Friar Lacrosse Camps, Providence College, its trustees, officers, agents and employees from any and all liability, damage and claims of any nature arising from or in any way related to my child's participation in this program. 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 or any other site utilized by 24 LACROSSE, LLC OR ANY EVENT UNDER DIRECTION BY CHRIS BURDICK** in connection with the camp program. In consideration of your enrolling my son / daughter in the program, I agree to indemnify and hold harmless **24 LACROSSE, LLC (FORMERLY Friar Lacrosse Camps, LLC), Chris Burdick and any staff employed by 24 LACROSSE, Providence College and any other site utilized by 24 LACROSSE, 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 any **Friar Lacrosse Camp operated program, clinic or 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 any of the programs offered by **24 LACROSSE, LLC**.

Name of emergency contact _____ Phone _____ Name of family physician _____ Phone _____

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

Signature _____ Date _____

List additional persons who are permitted to pick your child up from camp

Please indicate (if applicable) HMO PPO

Insurance company Insurance company address – street number and name _____

City _____ State _____ ZIP code _____

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

PLEASE FAX WITH PHOTO COPY OF INSURANCE CARD – FRONT AND BACK TO 401-865-1231