



Statement of parent/guardian informed consent
for participation and permission to provide emergency medical services

WARNING : ASSUMPTION OF RISK

I, the undersigned parent/guardian of \_\_\_\_\_, a minor, hereby give my permission for him/her to participate in \_\_\_\_\_. As I sign, I know that vigorous physical (Name of camp)

activity presents certain dangers of mild, moderate, or severe injury to my son/daughter. Further, as I sign, I know catastrophic injuries causing death, permanent paralysis or loss of organs can occur as a result of physical activity. I acknowledge that the Camp, Memorial Union, and Emporia State University officials, do not have control over these dangers. My child has been instructed to follow the directions of camp officials.

PERMISSION TO PARTICIPATE

I, the undersigned, state that to the best of my knowledge my child is physically capable of participating in a vigorous daily schedule along with rigorous physical activity. Also, I verify the medical history of my child is complete and identifies any factors which might limit his/her physical activity. In consideration of the benefits my child will receive through this camp participation, I hereby release ESU, the Memorial Union Corporation, the State of Kansas, their employees and agents from any liability or claims arising from this activity, except as such claim may be made under the Kansas Tort Claims Act. I give my permission to participate.

PERMISSION FOR MEDICAL TREATMENT

I, the undersigned, hereby give permission for my minor child to receive emergency medical treatment or transfer to appropriate medical facility as deemed appropriate by attending physician. Further, I acknowledge reading and understanding the above statements and truthfully completing the medical history portion of this form.

I, the undersigned, provide the following medical history of the above named minor.

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_
Home Address \_\_\_\_\_
Parent or Legal Guardian \_\_\_\_\_ Telephone \_\_\_\_\_
Full Address \_\_\_\_\_ Family Physician
Address \_\_\_\_\_ Telephone \_\_\_\_\_
YES NO 1. Allergies \_\_\_\_\_
YES NO 2. Current Medication \_\_\_\_\_
YES NO 3. Have you had any major medical illnesses or injuries (e.g., anemia, diabetes, epilepsy, bleeding disorders, thyroid, etc.) \_\_\_\_\_
YES NO 4. Heart Conditions (murmur, heart disease) \_\_\_\_\_
YES NO 5. Respiratory Conditions (asthma, hay fever) \_\_\_\_\_
YES NO 6. Been Knocked Unconscious, How Often, Dates, Recommendation \_\_\_\_\_
YES NO 7. Has There Ever Been A Medical Problem With The Following:
Eyes \_\_\_\_\_ Kidneys \_\_\_\_\_ Ears \_\_\_\_\_ Hernias \_\_\_\_\_ Testicles \_\_\_\_\_
YES NO 8. Operation or Surgery \_\_\_\_\_
YES NO 9. Fractures (broken bones) \_\_\_\_\_
YES NO 10. Ever Fainted During Exercise. (Explain) \_\_\_\_\_
YES NO 11. Overnight Hospitalizations (Explain) \_\_\_\_\_

Do you have Hospital (Medical) Insurance? \_\_\_\_\_ Covered by Parents Policy? \_\_\_\_\_ Own Policy? \_\_\_\_\_
Name of Company \_\_\_\_\_ Policy Number \_\_\_\_\_
Company Address \_\_\_\_\_
In case of Emergency contact: Name (Parent/Guardian) \_\_\_\_\_
Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_
Home Telephone (\_\_\_\_) \_\_\_\_\_ Business Telephone (\_\_\_\_) \_\_\_\_\_

STATE OF:

COUNTY OF:

Witness this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_

(Legal Guardian Signature) \_\_\_\_\_ (Camp Name) \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_, in testimony whereof, I have hereunto set my hand and official seal the day and year aforesaid.

Notary Public \_\_\_\_\_ My term expires: \_\_\_\_\_