

# GREG CANNELLA'S ALL-STAR LACROSSE CAMP

287 River Drive- Hadley, MA 01035 - (413) 545-3782

## SECTION I: (TO BE COMPLETED BY PARENT OR GUARDIAN)

Camper's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father: \_\_\_\_\_ Day Tel.: \_\_\_\_\_ Eve. Tel.: \_\_\_\_\_

Mother: \_\_\_\_\_ Day Tel.: \_\_\_\_\_ Eve. Tel.: \_\_\_\_\_

Guardian is:  Father  Mother  Other (Name): \_\_\_\_\_

Address: \_\_\_\_\_ Tel.: \_\_\_\_\_

Name of emergency contact (relation to participant): \_\_\_\_\_

Day Tel.: \_\_\_\_\_ Eve. Tel.: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Tel.: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Tel.: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION:** The camp provides limited excess medical athlete accident insurance to respond to any eligible medical expenses not covered by family insurance. Parents or guardians will be billed directly for onward referral to insurance carriers.

**Camper's cannot be registered without providing complete insurance information.**

Medical Insurance Company Name: \_\_\_\_\_ Policy#: \_\_\_\_\_

In case of medical emergency, I hereby give permission to the College Health Service Staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

## SECTION II: CAMPER WAIVER AND RELEASE OF LIABILITY

In consideration of being allowed to participate in the GREG CANNELLA'S ALL-STAR LACROSSE CAMP (the "Camp") and related events and activities, the undersigned acknowledges, understands, and agrees that:

1. I hereby agree to behave in a responsible manner during the camp week. I understand that anyone who does not follow the rules of the camp will be sent home.
2. The risk of injury from the activities involved in the program of the Camp is significant, including potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist; and,
3. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE of the Company, its officers, shareholders, directors, officials, agents, coaches and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable, owners and lessors of premises used to conduct the Camp (the "Releasees") and I assume full responsibility for my Participation; and,
4. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest staff/official immediately; and
5. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS THE RELEASEES WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss, or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE UNLESS CAUSED BY THE WILLFUL, WANTON AND INTENTIONAL CONDUCT OF THE RELEASEES.

I HAVE READ THE RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND AND IT'S TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

X (Camper's Signature) \_\_\_\_\_ Date Signed: \_\_\_\_\_

This is to certify that I, as parent/guardian with legal responsibility for this Camper, do consent and agree to his/her foregoing Waiver and Release of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify the Releasees from any and all liabilities incident to the Camper's involvement or participation in the Camp as provided above.

X (Parent/Guardian Signature) \_\_\_\_\_ Date Signed: \_\_\_\_\_

## Medical and Immunization History

### SECTION III: PHYSICAL EXAMINATION

(MUST BE IN THE PRECEDING 12 MONTHS AND DONE BY A MEDICAL PROVIDER)

Medical history (Please note significant disorders):

Allergies: \_\_\_\_\_ Heart: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_

Kidney: \_\_\_\_\_ Whooping: \_\_\_\_\_ Cough: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Lung: \_\_\_\_\_ Varicella: \_\_\_\_\_

Disabilities: \_\_\_\_\_ Neurological: \_\_\_\_\_ Other: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

Summary of Significant Treatment Program, including Names/Dose of Medications to be used while at camp:

(Medications MUST be in an airtight container with the original label): \_\_\_\_\_

### SECTION IV: IMMUNIZATIONS

| Immunization   | Dates  | Immunization  | Dates   |
|--|--|---|---|
| Has completed primary series of tetanus/diphtheria? (Four doses) Yes _____ No _____  |  |   |   |
| Completed primary series of polio immunization? Yes _____ No _____   |  |   |   |
| Primary Series - Type of vaccine: OPV IPV E-IPV ____/____/____   |  |   |   |
| Last Booster - Type of vaccine: OPV IPV E-IPV ____/____/____   |  |   |   |
| Diphtheria/tetanus (Td)<br>Must be within last ten years<br>(Complete only if primary series was more than ten years ago.)   | Month Day Year<br>____/____/____   | Mumps or MMR #1<br>Must be AFTER age 12 months or Positive Mumps Titer (blood test)                         | Month Day Year<br>____/____/____  |
| Measles #1<br>(Rubeola, Red Measles) - Must be AFTER age 12 Months<br>or<br>MMR #1<br>or<br>Positive Measles Titer (blood test)  | Month Day Year<br>____/____/____<br><br>____/____/____<br><br>____/____/____ | Rubella or MMR #1<br>(German Measles) - Must be AFTER 12 Month<br>or<br>Positive Rubella Titer (blood test) | Month Day Year<br>____/____/____<br><br>____/____/____                    |
| Measles #2(Rubeola, Red Measles) - Must be at least 30 days AFTER first dose<br>Or<br>MMR #2   | Month Day Year<br>____/____/____<br><br>____/____/____                       | Hepatitis B<br>Those born AFTER 1/1/92<br>Dose #1<br>Dose #2<br>Dose #3                                     | Month Day /Year<br><br>____/____/____<br>____/____/____<br>____/____/____ |
| Medical exemption: The above named person does not have one or more of the required immunizations because he/she has medical problems that precludes the _____ vaccine(s). |  |   |   |

Health Care Provider Signature and/or Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_ Tel.: \_\_\_\_\_

Please mail to:

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