Medical Waiver

(Three Signatures Required)

Name of Camper: _____

Age: _____

Please complete the following questions so that we can ensure the health and safety of your child. Thank you!

Does this camper require an inhaler? YES / NO

If your child does need an inhaler, please make sure to write his or her name on the inhaler and bring it every day. You can leave it with the Athletic Trainer and pick it up after each session.

Does this camper have any allergies to bee stings? YES / NO

Does this camper have any food allergies? YES / NO Please specify what foods:

_____

_____

For YES answers to bee stings or food allergies: Does she have an Epi Pen? YES / NO

If your child does have an Epi Pen, please bring it to camp every day with his or her name written on it. You can leave it with the Athletic Trainer and pick it up after each session.

Is this camper diabetic? YES / NO

If she is, does she require insulin or glucose tablets? YES / NO

If your child does have insulin or require other dietary aids for treatment for her diabetes, please write his or her name on it and bring it to camp every day. You can leave it with the Athletic Trainer and pick it up after each session.

Please list any current medical injuries or other illnesses that the camp staff should be aware of: _____

_____

_____

Authorization for Self-Administration of Emergency Medications **(Epi-Pens & Inhalers Only)**

Participant's Name:_____ Camp Session _____ Date of Birth: _____Date:_____
Medication: _____
Dosage: _____
Time: _____
Reason for Medication: _____
Any Side Effects or Adverse Reactions? _____

I hereby certify that the child listed above has been instructed in and is fully capable of the self-administration of the above emergency medication. The child is capable of carrying this medication during Sum It Up For Girls programs, and to self-administer it.
Physician's Name: (Please Print)_____
Physician's Signature (Optional): _____
Physician's Phone: _____
Parent/Guardian's Signature: _____

Medication Administration Request

(Prescription and Over Counter) Participant's

Name:_____ Camp Session: _____
Date:_____ Date of Birth: _____

Medication: _____
Dosage: _____
Time: _____
Reason for Medication: _____
Any Side Effects or Adverse Reactions? _____
Physician's Name: (Please Print) _____
Physician's Signature (optional):_____

Physician's Phone: _____

To Be Signed by Parent/Guardian:

I give my permission for the above medication to be administered to my child at any Sum It Up For Girls event/activity. I realize that any changes or modifications of this order will require a written authorization from this physician.
Parent/Guardian's Signature: _____

Date: _____

Sum It Up Lacrosse
908-477-4239