

MEDICAL INFORMATION AND RELEASE
2010 BAYLOR UNIVERSITY CAMP
MINOR OR ADULT PARTICIPANT
(PLEASE COMPLETE FORM IN BLUE OR BLACK INK)

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

DATE OF BIRTH: _____
(MO.) (DAY) (YEAR)

HEALTH/ACCIDENT INSURANCE CARRIER: _____

POLICY NO.: _____ GROUP NO.: _____

PERSONAL PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

PHYSICIAN'S PHONE NUMBER: _____
(AREA CODE) (NUMBER)

PARENT, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY. PLEASE CONTACT:

NAME _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME TEL: _____ WORK TEL: _____ CELL TEL: _____
(AREA CODE) (NUMBER) (AREA CODE) (NUMBER) (AREA CODE) (NUMBER)

Please list any chronic or acute medical problems (Continue on back if needed): _____

Please explain: _____

List any allergies to food, pollen or medicine: _____

List any medications being taken at present: _____

I ACKNOWLEDGE THE PARTICIPANT'S IMMUNIZATIONS ARE CURRENT: _____ YES _____ NO

I or MY CHILD plan to attend a BAYLOR UNIVERSITY CAMP, hereinafter referred to as "CAMP." I fully realize that injury or illness could result from or during MY or MY CHILD'S participation in the CAMP. In case of accident or illness, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

ADULT PARTICIPANT or PARENT/LEGAL GUARDIAN'S SIGNATURE _____

PLEASE PRINT CAMP PARTICIPANT NAME: _____

IF MINOR, PLEASE PRINT PARENT'S NAME: _____