

**MEDICAL INFORMATION AND RELEASE**  
**2011 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: \_\_\_\_\_