Parent/Guardian Consent, Medical Release and Release from Liability Agreement

Please read the following information carefully before signing.
All blanks must be completed. Please read the following information carefully before signing.

Activity: _____ Activity Time Period: _____
Activity Sponsor: _____
Participant Name: _____
Parent/Guardian Name(s):_____

In consideration for allowing Participant to participate in Activity, I/we, as parents and/or guardians of Participant, agree to the following:

Authorize Participant to participate in the Activity for the Activity Time Period stated above.

Release, indemnify and hold harmless the Activity Sponsor and University from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of Activity Sponsor or University, arising out of the participation of Participant in the Activity.

Prior to the commencement of the Activity, I/we were made aware of the nature of the Activity, had sufficient opportunity to inquire further, and understand the Activity has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.

While participating in the Activity, Participant is subject to the policies, rules and regulations of the University and Activity Sponsor. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Activity. Further, any Participant repeatedly disobeying University or Activity Sponsor policies, rules or regulations may be expelled from the Activity.

Authorize Activity Sponsor, its employees, clinicians, trainers, nurses and agents (collectively, "Activity Sponsor") the authority to seek, obtain, and approve any medical care and treatment including, but not limited to x-ray examination, anesthetic, medical, dental or surgical diagnosis, or treatment and medical care which may be recommended and provided under the general supervision of any physician or surgeon, for Participant which, in their judgment, is necessary for the health and well-being of Participant during his/her participation in the Activity. I/We further agree that I/we are(am) solely responsible for any costs incurred and agree to hold the Activity Sponsor and the Regents of the University of Michigan, their employees and agents (collectively, "University") harmless for any liability arising out of any good faith action taken in obtaining medical treatment for Participant.

The above agreements are binding upon us, our estates, heirs, representatives and assigns.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Participant Signature _____ Date _____

HEALTH INSURANCE INFORMATION SHEET

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name _____

Participant's Address _____

Participant's Phone Number _____

Date of Birth _____

Insurance Company Name _____ Effective Date _____

Address of Insurance Company _____

Phone Number of Insurance Company _____ Group #_____

Policyholder's Name _____ Policy #_____

Policyholder's Address _____

Relationship to Participant _____

Contract #_____ Employee Number _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.

Name of Personal Physician _____ Phone _____

Physician Address _____

Person(s) to be contacted in case of Emergency:

Name _____ Relationship_____
Address _____
Daytime Phone _____ Evening Phone_____ Cell Phone_____

Name _____ Relationship_____
Address _____
Daytime Phone _____ Evening Phone_____ Cell Phone_____

UM Summer Camp Health Questionnaire
(To be filled out by Participant's Parent or Guardian)

Participant_____ **Birthdate**_____/_____/_____ **Sex:** M F

Address_____ **Phone** ( )_____-_____

Family Physician_____ _____**Phone**( )_____-_____

Parent/Guardian_____**CampType**_____

Medications: (indicate medication(s) which is/are taken on a regular basis:

Medication Name _____ Dosage_____Directions_____

Medication Name_____ Dosage_____Directions_____

Note: Participant should bring an adequate supply of their medication(s) with them.

Explain any "yes" answers below:		**Yes**	**No**
Nervous System:	Has the participant ever...		
1.	had a head injury?.....	☐	☐
2.	been knocked out or unconscious?.....	☐	☐
3.	had a seizure?.....	☐	☐
4.	had a stinger, burner or pinched nerve?.....	☐	☐
5.	had any problems with his/her eyes or vision?.....	☐	☐
6.	worn glasses, contacts or protective eyewear?.....	☐	☐
Circulation:	Has the participant ever…		
7.	been dizzy or passed out during or after exercise?.....	☐	☐
8.	had chest pain during or after exercise?.....	☐	☐
9.	tired out more quickly than their friends during exercise?.....	☐	☐
10.	been told he/she has a heart murmur?.....	☐	☐
11.	had racing heart or skipped heartbeats?.....	☐	☐
12.	had anyone in their family died of heart problems or sudden death before age 50?.....	☐	☐
Respiratory:			
13.	Does the participant ever have trouble breathing or cough during or after exercise?.....	☐	☐
Musculoskeletal:			
14.	Does he/she frequently have heat or muscle cramps?.....	☐	☐
15.	Do he/she use any special equipment (pads, braces, neck rolls, mouth guards, etc.)?.....	☐	☐
16.	Has she/he had any injuries of any bones or joints?.....	☐	☐

☐ Head ☐ Chest ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle
☐ Neck ☐ Back ☐ Forearm ☐ Hand ☐ Thigh ☐ Calf ☐ Foot

Skin:			
17.	Does she/he have any skin problems (itching, rashes, acne, etc.)?.....	☐	☐
General:			
18.	Has he/she ever had surgery or been hospitalized?.....	☐	☐
19.	Has he/she had any other medical problems (infectious mono, diabetes, high blood pressure, etc.)?.....	☐	☐
20.	Is he/she taking any medications or pills?.....	☐	☐
21.	Does he/she have any allergies (medicines, bees or other stinging insects)?.....	☐	☐
22.	When was the participant's last tetanus shot?_____		
23.	When was the participant's last measles immunization?_____		
Females only:			
24.	When was the participant's first menstrual period?_____		
25.	When was the participant's last menstrual period?_____		
26.	What was the longest time between the participant's periods last year?_____		

Explain "Yes"answers:

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I, as parent/guardian, also consent to the examination of the Participant. Any abnormalities will be referred to the Participant's personal physician or appropriate specialist physician.

Signature of Participant_____ **Date**_____/_____/_____

Signature of parent/guardian _____

Physical Examination
(To be filled out by Child's Doctor)

Date_____/_____/_____

Name of Participant _____ **Age**_____ **Birthdate**_____/_____/_____

Each participant must EITHER attach a copy of a physician conducted sports examination applicable to this current academic year OR have a physician complete and then sign the form below.

Clearance: (circle one)

A. **Cleared**

B. **Cleared after completing evaluation / rehabilitation for:**_____

C. **Not cleared for:** **Collision**

Contact

Noncontact: Strenuous Moderately strenuous Nonstrenous

Due to:_____

Recommendation:_____

_____

Signature of physician_____ **Date**_____/_____/_____

Physician Address_____

Physician Phone_____