Bryant University Bulldog Elite Camp 2015
Medical Information
(Please print all information requested)

ATTENDEE_____
Last Name **First Name** **Middle Name**

1. **PERMISSION FOR EMERGENCY TREATMENT: I hereby grant permission to the BRYANT UNIVERSITY BULLDOG ELITE CAMP to hospitalize and secure proper treatment for my daughter_____ in case of a surgical or medical emergency, major or minor provided, she is unable to communicate with me, and when delay might endanger the life or health of my daughter.**

2 **PERMISSION TO PARTICIPATE: I individually and as the father/mother/or guardian, do hereby give my permission to my daughter to participate in the BRYANT UNIVERSITY BULLDOG ELITE CAMP, and use the facilities of Bryant University in connection with the camp program. In consideration of your enrolling my daughter in the camp, I agree to indemnify and hold harmless Bryant University and all it's trustees, officers, agents and employees from all claims, liability, loss and damage and expense which may in any way arise from my daughter's participation in the BRYANT UNIVERSITY BULLDOG ELITE CAMP including with limitation, all claims which my daughter, her parent, or guardian may have for personal injuries to other person which are caused by my daughter. To the best of my knowledge and belief, my daughter is of sound health and I know of no reason why she cannot participate in the program offered by the BRYANT UNIVERSITY BULLDOG ELITE CAMP.**

3. **I am aware that the camp's medical insurance will cover only those cost that my own medical insurance does not cover.**

Signature_____Date_____

4. **Medical**

Camper's Present Age_____ Date of Birth_____

Mother's Name & Phone Number_____

Mather's Employer & Phone Number_____

Medical Insurance Company & Policy Number_____

Father's Name & Phone Number_____

Father's Employer & Phone Number_____

Medical Insurance Company & Policy _____

Nearest Relative or Friend In Case of Emergency If Parent Cannot Be Contacted:

Name_____ Phone Number _____

Family Doctor's Name & Phone Number _____

Date of Last Tetanus Shot_____ Wear Glasses/Contacts_____ Teeth Braces_____

Allergies to Medications _____

Please list any additional medical information that the clinic should be made aware of:

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