


APPENDIX A

Part One:

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT
UW–MILWAUKEE SPORT CAMP

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT THE CAMP OFFICE, AT TELEPHONE NUMBER (414) 229-2238 OR 1-800-896-CAMP.

CONSENT FOR MEDICATION ADMINISTRATION:

To the Parent(s) or Legal Guardian(s): If your son, daughter or ward will be under the age of 18 while at the University of Wisconsin-Milwaukee, it is camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be administered by the Camp Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below.

- ❑ No medication has been brought to camp.
- ❑ I want the medication or medical devices self-administered (age 14 and above only).
- ❑ I want the medication or medical device administered by the the Camp Sports Medicine Staff.
  However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward (e.g.,bee sting kits, inhalers).

Name of Medication(s): _____ Amount of Dosage to be Taken: _____

How is Medication Taken? _____ Time(s) of Day to be Taken: _____

Name of Prescribing Doctor: _____ Doctor's Phone Number: _____

Special Instructions: _____

_____	_____	_____	_____
Signature of participant (if 18 or older)	Date	Signature of Parent or Guardian (if Participant is under 18 years old)	Date

CONSENT FOR MEDICAL TREATMENT:

To the Parent(s) or Legal Guardian(s): If your son, daughter or ward will be under 18 while at our camp, it is our policy to secure your consent for medical treatment. By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury. By signing below you are stating that you are aware of and accept the risk inherent in the program activity.

_____	_____	_____	_____
Signature of participant (if 18 or older)	Date	Signature of Parent or Guardian (if Participant is under 18 years old)	Date

ASSUMPTION OF RISKS:

I understand that physical activity related to the Sport Camp, by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. Some of these involve strenuous exertions of strength using various muscle groups, some involve quick movement involving speed and change of direction, and others involve sustained physical activity, which places stress on the cardiovascular system. The specific risks vary from one activity to another, but in each activity the risks range from: 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as fractures, internal injuries, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death. I understand that the University has advised me to seek the advice of my physician before participating in this activity. I understand that I have been advised to have health and accident insurance in effect and that no such coverage is provided for my by the University or the State of Wisconsin. **I know, understand, and appreciate the risks that are inherent in the above-listed programs and activities. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.**

_____	_____	_____	_____
Signature of participant (if 18 or older)	Date	Signature of Parent or Guardian (if Participant is under 18 years old)	Date

HOLD HARMLESS, INDEMNITY AND RELEASE:

In consideration of permission for me to voluntarily participate in the Sport Camp, today and on all future dates, I, for myself, my heirs, personal representatives or assigns**,** agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-Milwaukee, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my participation in the above-listed program. This release includes claims based on the negligence of the Board of Regents of the University of Wisconsin System, the University of Wisconsin-Milwaukee, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence. **I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue**.

_____	_____	_____	_____
Signature of participant (if 18 or older)	Date	Signature of Parent or Guardian (if Participant is under 18 years old)	Date

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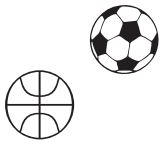
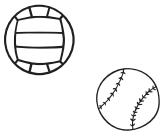
UNIVERSITY of WISCONSIN MILWAUKEE





Part Two:
SPORT CAMP
HEALTH HISTORY QUESTIONNAIRE

Please indicate any other sport camp you are attending at UWM with the dates. We will transfer your medical records to the other camp.

❑ Girls Basketball_____ ❑ Girls Soccer_____
❑ Boys Basketball_____ ❑ Boys Soccer_____
❑ Volleyball _____ ❑ Baseball _____
❑ Track _____ ❑ Tennis _____

Participant: _____
Last First Middle Initial

Home Address: _____
Street City State Zip

Parent/Guardian: _____ Relationship: _____

Home Phone: _____ Work Phone: _____
Area Code + Number Area Code + Number

Address (if different from above): _____
Street City State Zip

In case of an emergency or illness, if you are unable to be contacted, whom shall we notify:

Name: _____ Relationship: _____

Address: _____ Phone: _____
Street City State Zip Area Code + Number

Name of Physician: _____ Phone: _____
Area Code + Number

Name of Insurance Co.: _____ Policy #: _____

Camp/Event: Camp Dates:

Sex: ☐ F ☐ M Date of Birth: _____

Height: _____ Weight: _____

Does participant have allergic reactions to:

YES	NO	IDENTIFY
☐	☐	Penicillin
☐	☐	Other Antibiotics _____
☐	☐	Other Medicines _____
☐	☐	Insect Bites/Stings _____
☐	☐	Foods _____

Is the participant taking any medication(s) regularly?
☐ YES ☐ NO

If *YES*, identify medication:

_____
(Consent for Medication Administration Must Also Be Signed)

Immunization Record:

•	MMR (Measles, Mumps, Rubella)	Dose 1 - Immunization at 1 yr.	☐ YES ☐ NO
		Dose 2	☐ YES ☐ NO
•	Tetanus-Diphtheria		☐ YES ☐ NO
•	Year of last Tetanus Booster (must be within last 10 yrs.) _____		

Has the participant ever had major surgery or been hospitalized? ☐ YES ☐ NO

Please explain any significant operations, accidents or illnesses, and last medical attention and the reason:

_____
_____
_____

Does the participant have any physical conditions requiring special considerations? Explain.

_____
_____
_____

Has the participant ever suffered from, or are they currently experiencing, any of the following:

YES	*NO*		*YES*	*NO*	
☐	☐	**Allergies**	☐	☐	**High Blood Pressure**
☐	☐	**Asthma**	☐	☐	**Joint Injury/ Surgery**
☐	☐	**Bleeding Disorder**	☐	☐	**Kidney Disease**
☐	☐	**Cancer**	☐	☐	**Menstrual Difficulties**
☐	☐	**Colitis**	☐	☐	**Mental/Emotional Problem**
☐	☐	**Diabetes**	☐	☐	**Neck/Back Pain Injury**
☐	☐	**Epilepsy/Seizure Blackouts**	☐	☐	**Rheumatic Fever**
☐	☐	**Heart Disease**	☐	☐	**Tuberculosis**
☐	☐	**Hernia**	☐	☐	**Ulcer**

Other:

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