



# ROBERTS WESLEYAN UNIVERSITY

## Medical Release/Liability Form

*\*Return 2 weeks prior first week of camp (or sooner) to:*

Roberts Wesleyan University  
Voller Athletic Center  
2301 Westside Drive  
Rochester, NY 14624-1997

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street and number City State Zip code

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Mothers Name \_\_\_\_\_ Place of \_\_\_\_\_ Phone \_\_\_\_\_  
Employment

Fathers Name \_\_\_\_\_ Place of \_\_\_\_\_ Phone \_\_\_\_\_  
Employment

If not available in an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

PHYSICIAN'S Name \_\_\_\_\_ Phone \_\_\_\_\_

Operations or Serious Injuries (Date) \_\_\_\_\_

Chronic or Recurring Illness \_\_\_\_\_

Other Diseases or Details of above \_\_\_\_\_

Will your child take medicine during the camp week? Yes \_\_\_ No \_\_\_

If your child requires any medication (prescription and non-prescription) during camp hours you must come to camp and dispense the medication to your child.

*Note: If the child is able to do so he/she may self-administer medicine--under supervision, in the Director's office.*

**IMMUNIZATION HISTORY (Dates)**

Diphtheria \_\_\_\_\_ Haemophilus Influenza Type b \_\_\_\_\_ Tetanus Booster \_\_\_\_\_

Poliomyelitis \_\_\_\_\_ Varicella (chickenpox) \_\_\_\_\_ Measles Vaccine \_\_\_\_\_

Rubella (MMR) \_\_\_\_\_ Mumps \_\_\_\_\_ Hepatitis b \_\_\_\_\_

\*(verification by M.D. if has had a disease)

**SPECIAL NEEDS, RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP:**

Special Diet \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Swimming, Diving \_\_\_\_\_

Strenuous Activity \_\_\_\_\_

Other Activity \_\_\_\_\_

Date of last exam \_\_\_\_\_

Only people allowed picking up child \_\_\_\_\_

Anybody including you as parents or guardians might be required to provide a picture ID to pick up a child as deemed necessary by the Camp Director.

**Medical Release**

In an emergency, I hereby give permission for my son/daughter \_\_\_\_\_ to be examined by camp medical personnel. I also give permission to the licensed physician selected by the camp operator, to hospitalize, secure proper treatment, anesthesia, or surgery for my child in an emergency. I also give the camp director under the auspices of Roberts Wesleyan University permission to advise the hospital of our insurance information at the time of any treatment.

Insurance company \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of primary policyholder \_\_\_\_\_

\_\_\_\_\_  
Signature Date