

Steve Owens Baseball Camps
Medical Information
(Please print all information requested)

Camper _____
Last Name First Name Middle Name

1. **PERMISSION FOR EMERGENCY TREATMENT:** I hereby grant permission to the Steve Owens Baseball Camps to hospitalize and secure proper treatment for my son _____ in case of a surgical or medical emergency, major or minor provided, he is unable to communicate with me, and when delay might endanger the life or health of my son.

2. **PERMISSION TO PARTICIPATE:** I individually and as the father/mother/or guardian, do hereby give my permission to my son to participate in the Steve Owens Baseball Camps, and use the facilities of Bryant University in connection with the camp program. In consideration of your enrolling my son in the program, 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 son's participation in the Steve Owens Baseball Camps including with limitation, all claims which my son, his/her parent, or guardian may have for personal injuries to him or herself and any other person which are caused by my son. To the best of my knowledge and belief, my son is of sound health and I know of no reason why he cannot participate in the program offered by the STEVE OWENS BASEBALL CAMPS.

3. **I UNDERSTAND THAT ALL CAMPERS MUST HAVE PERSONAL HEALTH INSURANCE IN ORDER TO ATTEND AND PARTICIPATE IN CAMP.**

Signature _____ Date _____

4. **Medical**

Camper's Present Age _____ Date of Birth _____

Mother's Name & Phone Number _____

Mother'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 camp should be made aware of:

5. **Required: Parental/Guardian signature verification of date of last physical exam.** Date of exam must be within one year of camp date _____. A physician has examined the camper above and found him to be able to participate in all activities that are involved in baseball camp.

Physician's Name _____ Physician's Phone () _____

Parent/Guardian _____ Date _____

Parent/Guardian Signature _____