

HAYDEN SYNCHRO SUMMER EXPERIENCE CAMP 2012

Medical Emergency Contact: Form A

To be completed by Parent or Legal Guardian

PLEASE PRINT CLEARLY

Skater Info:

Name: Last _____ First _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Home Phone # _____

Parent/Guardian Info:

Mother's Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____

Father's Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____

Alternate Emergency Contact Information

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail _____

Primary Care Doctor/Dentist Information

Pediatrician's Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____

Dentist's Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____

Health Insurance

Insurance Carrier Name _____
Policy Number _____
Subscriber Name _____

Please return this document to Hayden Synchro Summer Experience Camp with you application.
Your registration is not complete and your skater can not participate in the camp without this information.

All four (4) pages must be completed and signed. Thank you.

This camp must comply with all regulations of the Massachusetts Department of
Public Health and be licensed by the Marlborough Board of Health.

HAYDEN SYNCHRO SUMMER EXPERIENCE CAMP 2012

Medical Fact Sheet: Form B

To be completed by Parent or Legal Guardian

Please accurately complete the following questions.

NAME OF SKATER

Date of Birth _____

Inhaler: If your child uses an inhaler, do you give him/her permission to keep the inhaler with him/her at the HSSEC Program and to use it as needed?
Yes _____ No _____ Not Applicable, my child does not use an inhaler _____

Epi-Pen: Will you be registering an Epi-Pen for your child on the first day of camp?
Yes _____ No _____
If so, my child is capable of administering the Epi-Pen without assistance _____ or
My child will need adult assistance in administering the Epi-Pen _____

Allergies: My skater is allergic to the following foods, medications, animals, or environmental factors:

The severity of reaction is _____ and the symptoms include the following

Medication: My child takes the following Medication (other than Inhaler or Epi-Pen)

Medication	Medical Condition	Amount per dose	# of doses per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Will the medication need to be administered at camp? Yes _____ No _____
(If yes, you must complete and sign an Authorization to Administer Medication form in addition to this form. The form will be emailed to you upon request.)

I hereby certify that my child is physically able to participate in the HSSEC and has no medical condition which would affect his/her participation.

Print Name _____

Signature _____ Date _____

HAYDEN SYNCHRO SUMMER EXPERIENCE CAMP 2012
Authorization to Treat, Release & Indemnify: Form C
To be completed by Parent or Legal Guardian

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
ASSUMPTION OF RISK, RELEASE AND INDEMNIFICATION

In consideration of the opportunity to participate in The Hayden Synchronized Summer Experience Camp ("HSSEC"), the undersigned (and his/her undersigned parent or guardian, if applicable), individually, and on behalf of his/her heirs, personal representatives, administrators, agents, successors and assigns (collectively referred to herein as "Participant"), AGREES TO ASSUME THE RISK AND RESPONSIBILITY, TO RELEASE AND TO INDEMNIFY The Hayden Synchronized Skating Teams ["HSST"], its directors, officers, members, employees, officials, committees, clubs, affiliates, representatives, agents, successors and assigns, including the host club and any other entity responsible for the hosting and/or conduct of the HSSEC Event, as follows:

1. Assumption of Risk and Responsibility.

Participant understands and appreciates the risks of injury that may occur in ice skating or in the course of preparing for, participating in and traveling to or from the HSSEC Event, acknowledges that Participant voluntarily engages in such activities with adequate knowledge of such risks and agrees that Participant assumes all legal and financial responsibility for (a) any and all injuries or damages, whether to person or property, that Participant may in any manner sustain in connection therewith or the conduct and management of the HSSEC Event, including such injury or damage that may result from the negligence of HSST or from some other cause and (b) subject to any applicable insurance coverage, all treatment, hospitalization and other care rendered to Participant in the event of Participant's illness, injury or other emergent circumstance in connection with Participant's participation in the HSSEC Event.

2. Medical Treatment, Conditions and Consents.

Participant recognizes that, in the event of his/her illness, injury, or medical or other emergent circumstances while participating in and traveling to or from the HSSEC Event, and if Participant is disabled or incompetent to make appropriate decisions concerning treatment thereof (and, in the case that Participant is a minor, Participant's parent or legal guardian cannot be timely and conveniently contacted to participate in the making of necessary decisions), HSST Representatives may have to make decisions and take necessary and appropriate action, with input from available medical personnel (and HSST coaches, if they deem it reasonable and appropriate), pertaining to Participant's treatment, hospitalization, or other care, and Participant agrees and consents thereto. In addition, in conjunction with Participant's participation in the HSSEC Event, I further authorize and consent to the release of any pertinent medical information and records regarding the treatment, diagnosis, and/or examination of myself to HSST.

3. Release and Indemnification.

Participant hereby fully and forever releases, discharges, holds harmless and agrees to indemnify HSST from and against any and all liabilities, claims, demands, litigation, damages and judgments, present or future, known or unknown, valid or invalid, direct or consequential, together with reasonable costs and attorney fees, which result directly or indirectly from damages, losses, injuries or death to Participant, Participant's property, or to other persons or property incurred during or in connection with any activities associated with or being a part of the HSSEC Event and the conduct and management thereof, including any participation, travel or medical treatment, hospitalization or other care rendered in connection with the Event, whether such loss, damage, injury or death results from the negligence (other than in the case of gross negligence) of HSST or from some other cause.

Printed Name of Participant/Skater

Printed Name of Parent or Guardian

Signature of Participant
(Or Parent or Guardian if Under Age 18)

Date

HAYDEN SYNCHRO SUMMER EXPERIENCE CAMP 2012

Medical and Immunization History: Form D

To be completed by the Child's Primary Care Physician

(Note: A standard Physician's Camp Form will be accepted provided it contains the following information and includes a copy of a physical exam performed on or after June 15, 2010 (within 2 years of camp attendance)).

NAME OF SKATER

Date of

Birth _____

Immunization History

	Date	Date	Date	Date
DPT				
DT				
Polio				
MMR				
HB-Conjugate				
Varivax				
Hep A				
Hep B				
Other				

TB Screen: No Risk ____ At Risk ____
If at risk, TB/PPD applied on ____/____/____ Positive _____ Negative _____

History of Reaction to food, serum, drugs or medicine: No ____ Yes ____
Explain _____

Date of Physical Exam _____ Sex ____ Age ____ Height _____ Weight _____ BP _____

#	System	Satisfactory	Unsatisfactory	Describe Abnormality
1	Skin			
2	Eyes			
3	Eats			
4	Nose, Throat			
5	Neck, Thyroid			
6	Chest, Lungs			
7	Heart, Heart Rate			
8	Heart Rhythm			
9	Liver, Kidney, Spleen			
10	Hernia			
11	Back, Spine			
12	Joints			
13	Neurological			

The following abnormalities should be noted:

Please indicate any medications taken and how many times per day

The patient does ____ does not ____ have a history of emotional, psychological, or psychiatric disturbance.

The patient may participate in camp activities: without restrictions
 with the following restrictions

Primary Care Physician Information:

Name (Print) _____ Signature _____
Address _____ Phone _____