Medical and Surgical Treatment Authorization:

I hereby authorize and give my consent to the health authorities of Washington State University or any licensed physician to perform upon or administer to: (participant name)________________________ any reasonable necessary medical or surgical treatment. I also give my permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, blood transfusions, and minor operations and procedures.

In the event of indicated major surgery, or major operation, the University authorities or physicians are not hereby excused from making a reasonable attempt to contact me by phone or mail before relying upon this authorization. This authorization does not entitle the service or physician to render any medical or surgical treatment without the participant’s personal consent, unless the participant is unable to give consent. This permission is good only while the participant is attending a camp sponsored by Washington State University and only until the participant has attained his/her eighteenth birthday.

I freely sign this authorization in consideration for permission for my child or ward to participate in camp. I understand that I will be responsible for any medical expenses in connection with the participant’s attendance at this camp.

I HAVE READ THIS FORM AND I AM SATISFIED THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE.

_________________________________  ________________________________
Signature of Parent or Guardian      Printed Name

_________________________________
Relation to Participant

_________________________________
Date
Emergency Information and Release Form

As parent/guardian, I hereby authorize the directors and staff of the WSU Horn Camp to act for me according to their best judgment in any emergency requiring medical attention. I hereby waive and release WSU Horn Camp and Washington State University. I know of no medical or physical problems which might affect my child’s ability to participate in this program. I will be responsible for any medical or other charges in connection with his/her attendance at WSU Horn Camp. I have read the rules and regulations of WSU Horn Camp and my child and I agree to abide by them. I understand that failure to abide by the rules and regulations may result in the student being dismissed from the program.

Student’s Name ___________________________ Birth Date ________________

Parent/Guardian’s Name ________________________________________________

Parent/Guardian’s Address ______________________________________________

Day Phone ___________ Evening Phone ___________ Emergency Phone __________

Special Medical Conditions (attach additional page if necessary)

________________________________________________________________________

Allergies to drugs:  ____ Yes  ____ No  If yes, please list: __________________________

Allergies to foods:  ____ Yes  ____ No  If yes, please list: __________________________

Allergies to bee stings that require medication  ____ Yes  ____ No

Special dietary restrictions ________________________________________________

Other pertinent information (including medications the student is currently taking)

________________________________________________________________________

Insurance Company Name ________________________________________________

Insurance Company Address ______________________________________________

Policy Number ___________ Group Number ___________ Subscriber’s Name _________

Family Physician _______________ Phone number _____________________________

Participant Signature ______________________________________ Date ____________

Parent/Guardian Signature ______________________________________ Date ____________