

# Cornell Sports School Medical Form

Participation is prohibited without this completed form!

Sport(s): \_\_\_\_\_ Camp dates: \_\_\_\_\_  
(one form allows camper to participate in multiple camps)

Camper's name: \_\_\_\_\_ Gender: boy girl Age: \_\_\_\_\_

Primary contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day ph: (\_\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_\_) \_\_\_\_\_ Other ph: (\_\_\_\_\_) \_\_\_\_\_

Emergency contact (other): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance co.: \_\_\_\_\_ Name of policy holder: \_\_\_\_\_

Policy/ID no.: \_\_\_\_\_ Insurance co. phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance co.  
address: \_\_\_\_\_

## Medical information below - Physician's signature required

**MEDICATIONS AT CAMP:** Is it necessary to administer medication at camp (check one)? YES NO

Medications & dosages: \_\_\_\_\_

**All medication MUST** be in its original container with an accurate pharmacy label and **MUST** be accompanied by physician's orders. All medications **MUST** be given to the Medical Director at check-in. This policy applies to **OVER-THE-COUNTER** and **PRESCRIPTION** medications!

Allergies to Medications: \_\_\_\_\_

Medical conditions, even if controlled (diabetes, seizures, etc.) \_\_\_\_\_

Date of most recent immunizations: Tetanus \_\_\_\_\_, Measles \_\_\_\_\_, Mumps \_\_\_\_\_

Rubella \_\_\_\_\_, Diphtheria \_\_\_\_\_, Poliomyelitis \_\_\_\_\_

Hemophilus influenza type b \_\_\_\_\_, Hepatitis b \_\_\_\_\_, Varicella (chicken pox) \_\_\_\_\_

I have examined \_\_\_\_\_ and hereby certify he/she is able to participate in athletic activities.

\_\_\_\_\_  
\*Physicians Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

\*You may attach a recent copy (within the past year) of a school physical (with physician's signature) if your child has no new medical conditions that limit his or her participation in sport activities. Complete immunization records may also be attached.

## Medical Treatment Authorization

In the event of an injury or illness, I give permission for my child, \_\_\_\_\_ to be treated by Cornell's medical staff, and/or emergency room staff at the Cayuga Medical Center or Convenient Care Center. I also give permission for medical staff to administer any medications as indicated above. In addition, I consent to have Cornell or above service providers use and disclose my child's protected health information for payment, treatment and health care operations purposes. Protected health information includes medical, billing and demographic information collected and/or created by Cornell or above service providers. I understand that I will be responsible for all charges for health services by Cornell or off-campus providers.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date