FUTURE LEADER CAMP

Medical Release & Waiver Form

Participant's Full Name: ____
Last First MI Preferred

Gender: M or F DOB: ________________ Height (Inches):__________ Weight (Pounds):__________

Address: ____
Street City State Zip

MEDICAL INFORMATION – Check the Appropriate Box	YES	NO	N/A
If he/she has braces does he/she have the proper equipment to care for them?			
If he/she wears contact lenses, does he/she have a pair of glasses in case of loss?			
Does he/she take any type of medication? Please list below.			
Does he/she have any allergies (medications)? Please list below.			
Does he/she have any special dietary needs or allergies to food?			
Is he/she allergic to bee stings? Indicate below if they have a bee sting kit.			
Has he/she had any injury/surgery requiring inpatient care?			
Is there any history of a sports or other type hernia?			
Does he/she have scoliosis or any back trouble?			
Does he/she have any painful/trick joints?			
Is there any history of orthopedic problems to include fractures?			
Is there any history of concussions or head injury?			
Does he/she have difficulty standing for long periods of time?			
Has he/she ever been seen by a mental health care professional?			
Is there a history of eating disorders such as Anorexia or Bulimia?			
Has he/she been a sleepwalker since age 12?			
Is there any history of asthma or respiratory problems?			
Is there any history of fainting, epilepsy or seizures?			
Is there any history of migraine headaches?			
Is there a history of heart murmur or heart problems?			
Is there any history of blood disorders to include high blood pressure and/or hemophilia?			
Is there any history of addiction or treatment for drug or alcohol abuse?			
Does he/she use tobacco products of any kind?			
Are there any other medical conditions that might influence his/her ability to participate?			

If you answered YES to any of the above questions please explain below or on a separate sheet of paper:

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EMERGENCY CONTACT INFORMATION

Name: ________________________________

Relationship: ____________________________

Daytime #:______________________________
Include Area Code

Evening #:______________________________
Include Area Code

Name: ________________________________

Relationship: ____________________________

Daytime #:______________________________
Include Area Code

Evening #:______________________________
Include Area Code

MEDICAL RELEASE & WAIVER STATEMENTS

Please insert the participant's name on the blank lines unless otherwise stated.

I hereby give permission for _________________________to attend the Norwich University Future Leader Camp,

from _____________________ to _____________________.
day/month/year day/month/year

I hereby consent to and authorize, if necessary, Norwich University to disclose information from this medical record relating to the identity, diagnosis, prognosis, or treatment of _________________________ to the administration, insurance company, hospital, physician, or any source deemed necessary by Norwich University while he/she is in attendance at the Future Leader Camp.

I hereby consent and authorize, if necessary Norwich University to obtain any medical, dental or emergency medical care, which is deemed necessary by qualified personnel while _________________________ is in attendance at the Future Leader Camp.

I understand that Norwich University will notify me as soon as possible of any medical problem and/or action requiring the attention of a health care professional on behalf of _________________________.

I understand that any financial responsibilities, which are incurred by _______________________ as a result of medical/dental injury or illness, will be assumed by me, or my medical insurance carrier.

I hereby release any and all rights and claims for damages against Norwich University, its representatives and assigns, from any and all injuries suffered by _________________________ as a result of his/her participation in the Future Leader Camp. This waiver/release of liability extends to my/our heirs, executors, administrators, and assigns.

I hereby affirm that he/she is physically fit to be an active participant in the Future Leader Camp and endure the rigors of a physical training and adventure program, except as noted on the reverse of this page.

Parent/Guardian(s) Printed Name(s):___________________________/_______________________________

Parent/Guardian(s) Signature(s):______________________________/_______________________________

Relationship: ____ Date: ____________________________
day/month/year

MEDICAL INSURANCE INFORMATION

Policy Holders Full Name: ____
Last First Middle

Name of Insurance Company: ____________________________ Policy #:__________________________

Address of Insurance Company: ____

Insurance Company Phone Number: ____
(Include Area Code)

PLEASE ATTACH A PHOTO-COPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD.