In order to participate in the Syracuse Summer Showcase each player will need to EMAIL all the items below upon completion of their online registration. Your registration/spot in the showcase is not complete without payment or the items below.

Please EMAIL everything to the address below:

kcarcaterra@united-lacrosse.com

ITEMS TO MAIL

1. Copy of the athletes' immunization record
2. Copy of the front and back of their health insurance card
3. Completed Health Forms (pages 2-3 of this packet)
4. Completed Medication for any player who needs to take medication during the event (page 4)

Syracuse Boys Lacrosse Camps 2017
Registration Sheet

Type/Date of Camp: _____

Player Information:

Last name: _____ First name: _____

Birthdate: ____/____/____ Age: _____ Graduation year: _____

Address: _____ City: _____ State: _____ Zip: _____

Team: _____ Position: _____ School: _____

Parent/Guardian Information:

First name: _____Last name: _____ Relationship to camper_____

Phone number: _____ Email: _____

Emergency Contact Information (to be contacted if parent cannot be reached)"

First name: _____ Last name: _____ Relationship to camper: _____

Emergency phone number: _____

This information must be accompanied by the signed waiver and completed health form before registration can be completed. COPIES OF THE PARTICIPANT'S IMMUNIZATION RECORD AND HEALTH INSURANCE CARD ARE REQUIRED BY THE ONONDAGA COUNTY HEALTH DEPARTMENT.

Syracuse University Clinic and Camp Health Form - 2017

A sports camp or clinic participant will not be permitted to attend a camp or clinic unless this form is completed, ***in it's entirety*** *, and returned no later than one week prior to registration. On-site registrants must have a completed form before participation will be permitted. PLEASE PRINT CLEARLY*

THOSE PARTICIPANTS REQUIRING TAPING OR SPLINTING FOR SPORTS PARTICIPATION MUST SUPPLY THEIR OWN TAPING AND SPLINTING SUPPLIES FOR PRE-EXISTING CONDITIONS.

Participant's Name: Gender : (circle one) Male Female

Last Name First Name

Participant's DOB: / / Age: Sport: Camp/Clinic name:

Parent/Guardian: Home Phone: ( )

Email address: Cell Phone: ( )

Address:

Street Number City State ZIP

If not available in an emergency, notify: 1 Number:

2 Number:

*******Please include a copy of your insurance card AND complete the following*******

Insurance Company:	Policy Holder Name:
Relation to Camper:	Policy Holder DOB: / /
Policy/Group #:	Policy Holder Employer
Primary Care Physician:	Insurance Company Phone Number:
Pre-approval Required? (circle one) YES NO	Contact Number: ( )

Immunization History - Please INCLUDE A COPY of CAMPER immunization record.	**General Medical Information -** Asthma: (Circle one) YES NO
List Current Medications:	Allergies:
	Food:
	Medications:
IF CAMPER IS BRINGING MEDICATION TO CAMPUS	Bee Stings:
PLEASE FILL OUT MEDICATION AUTHORIZATION FORM	Other:

PARTICIPANTS with the following conditions must provide written physician's clearance before attending a Syracuse Camp or Clinic. Please return an OFFICIAL LETTER of physician's clearance (for each item) with the form. Participants without official physician clearance will be withheld from competition until clearance is received in writing.

Please specify the condition in the space provided:

Fracture in the last 6 months:	Surgery in the past year:
Seizure disorder:	Heart Condition:
Diabetes:	Hemophilia/blood disorder:
Loss of organ:	Hospitalization in last 6 months:
Spinal, head injury or concussion:	Other Injury/Illness requiring ongoing care:

PARENT/GUARDIAN AUTHORIZATION and NOTIFICATION;

Meningococcal Meningitis is a bacterial illness affecting the brain. It can be spread by a cough, sneeze, kiss, sharing drinks, or by any other direct contact or airborne means of transportation. Therefore, students/campers residing in small areas, such as dormitories, are at an increased risk for contracting the illness.

The signs and symptoms of Meningococcal Meningitis are similar to the common flu often making it hard to detect. The signs and symptoms include the following: high fever, nausea, vomiting, fatigue, headache, stiff neck/back, skin rashes, and confusion. Frequently, not all signs and symptoms occur, and the illness may progress rapidly. Treatment of Meningococcal Meningitis is antibiotic therapy.

A vaccination is available, and is an effective way to help prevent Meningococcal Meningitis, although any vaccine is not an absolute guarantee. There are rarely side effects associated with this vaccination. **Syracuse University summer camps will not provide the Meningitis vaccine.** Contact your family care provider for information regarding availability and associated costs of the vaccination.

I, the parent of legal guardian have received, reviewed, and understand the above information regarding Meningococcal Meningitis and my son/daughter has either received the immunization within the past 10 years preceding or has elected not to obtain the immunization against Meningococcal Meningitis.

To the best of my knowledge this health history information is correct and the person herein described has my permission to engage in all camp activities, with the exception of any physical limitations as described. In the event that I cannot be reached in an emergency, I hereby give permission to the medical personnel to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. I agree to indemnify Syracuse University and its employees for any claim which may hereafter be presented by our (my) son/daughter as a result of any such injuries.

Signature: Date:

Witness: Date:

***Please use the cups provided at each drinking station when utilizing the Gatorade/water. No use of personal cups or containers!**

SYRACUSE UNIVERSITY SUMMER CAMP

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY YOUTH CAMP PERSONNEL

If a summer camp chooses to administer medication, the Onondaga County Department of Health requires an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for camp personnel to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber, or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER DATE _____/_____/_____

Name of Camper_____Date of Birth_____/_____/_____
Street Address_____City_____State_____
Condition for which medication is being administered during camp hours_____

Medication (Name, dose, method of administration) _____Is this a controlled drug? Y N

Times of Administration: Breakfast Lunch Dinner Bedtime As Needed Other:_____
Medication shall be administered from ____/___/____ to ____/___/____
Relevant side effects to be observed, if any _____
If there are side effects, plan for management _____
Allergies, reaction to, or negative interaction with food or drugs? If YES, explain/list_____

Authorization by <u>Prescriber</u> for administration of above medication:

Prescriber's Name_____Phone(____) _____

Address_____City_____State_____

Prescriber's Signature_____Date_____

Authorization by Parent/Guardian for the administration of the above medication:

I have legal authority to consent to medication administration for the camper named above, including the administration of medication. I hereby request that the above medication, ordered by the authorized prescriber for my child be administered by the camp personnel designated by the Camp director. I understand that I must supply the summer camp with the prescribed medication in the original container and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order/camp. I agree to indemnify and hold harmless the Summer Camp Program Staff, Syracuse University, its Board of Trustees, officers and employees against any claims that may arise relating to my child's self-administration of medication.

Parent/Guardian Name_____Relationship_____
Address_____City_____State_____Phone (___) _____
Parent/Guardian's Signature_____Date_____

Authorization/Approval for Self-Administration of above medication:

<u>Self-administration</u> of medication may be authorized by the prescriber and parent/guardian approval for only <u>asthma medication and epi-pens.</u> SU camp personnel may witness the self-administration.

Prescriber's authorization for self-administration: YES NO _____
Signature Date

Parent/Guardian's authorization for self-administration: YES NO _____
Signature Date