LIPSCOMB

LIPSCOMB UNIVERSITY ATHLETICS
CAMP HEALTH CERTIFICATE

Parent/Guardian, please complete:

FULL NAME OF CAMPER (PRINT) ______________________________

DATE OF BIRTH ______________________________

EMERGENCY CONTACT and NUMBER ______________________________

NAME OF INSURANCE COMPANY ______________________________

POLICY HOLDER ______________________________

GROUP or POLICY NUMBER ______________________________

MOTHER'S NAME ______________________________

MOTHERS PHONE: CELL and WORK ______________________________

FATHER'S NAME ______________________________

FATHER'S PHONE: CELL and WORK ______________________________

PLEASE LIST MEDICATIONS CAMPER IS TAKING ______________________________

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LIST ALL KNOW ALLERGIES ______________________________

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LIST OTHER MEDICAL CONDITIONS ______________________________

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I hereby consent to allow my child to receive any necessary medical treatment for any condition of injury suffered while my child is attending any Lipscomb University camp. I understand that I will be responsible for any expenses incurred on his/her behalf in connection with such treatment. I herely authorize the directors of Lipscomb University Athletic Camp to act for me according to their best judgment in any emergency requiring medical attention.

PARENT/GUARDIAN SIGNATURE ______________________________

DATE: ______________________________

Please bring this completed form with you to registration. Do not send in advance.