Medical Waiver

Please complete the following questions so we can ensure the health and safety of your child. Thank you.

Name of Camper:		
Age of Camper:		
Does this camper require an inhaler?	YES	NO
If your child does need an inhaler, please make sure to write his or her name on the inhaler and bring it every day. You can leave it with the Athletic Trainer and pick it up after each session.		
Does this camper have any allergies to bee stings?	YES	NO
Does this camper have any food allergies?	YES	NO
Please specify which foods:		
For YES answers to bee stings or food allergies, does he/she have an Epi Pen?	YES	NO
If your child does have an Epi Pen, please bring it to camp every day with his or her name written on it. You can leave it with the Athletic Trainer and pick it up after each session.		
Is this camper diabetic?	YES	NO
If she is, does she require insulin or glucose tablets?	YES	NO
If your child does have insulin or require other dietary aids for treatment for her diabetes, please write his or her name on it and bring it to camp every day. You can leave it with the Athletic Trainer and pick it up after each session.		
Please list any current medical injuries or other illnesses that the camp staff should be aware of:		

Authorization for Self-Administration of Emergency Medications

(Epi-Pens & Inhalers Only)

Participant’s Name:	
Camp Session:	
Date of Birth:	
Medication:	
Dosage:	
Time:	
Reason for Medication:	
Any Side Effects or Adverse Reactions?	

To Be Signed by Parent/Guardian:

I hereby certify that the child listed above has been instructed in and is fully capable of the self-administration of the above emergency medication. The child is capable of carrying this medication during Swax Lax Lacrosse programs, and to self-administer it.

Physician’s Name (Please Print):	
Physician’s Signature (Optional):	
Physician’s Phone:	
Parent/Guardian’s Signature:	
Date:	

Medication Administration Request

(Prescription and Over-the-Counter)

Participant's Name:	
Camp Session:	
Date of Birth:	
Medication:	
Dosage:	
Time:	
Reason for Medication:	
Any Side Effects or Adverse Reactions?	

To Be Signed by Parent/Guardian:

I give my permission for the above medication to be administered to my child at any Swax Lax Lacrosse event/activity. I realize that any changes or modifications of this order will require a written authorization from this physician.

Physician's Name (Please Print):	
Physician's Signature (Optional):	
Physician's Phone:	
Parent/Guardian's Signature:	
Date:	