Bloomsburg University
Camp On-Site Registration Form

Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Check One: Boarder_____Commuter_____

Parent/Guardian Name _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Parent/Guardian Email _____

EMERGENCY CONTACT INFORMATION
(If different from above)

Name _____ Relationship _____ Contact # ( )_____

You must also complete the attached medical form (on back) and the photo/video release form (below)

Admin Use Only: Amount$_____ Circle one: CASH or CHECK

Check Number: _____ Last Name: _____

Photograph/Video Release

I authorize Bloomsburg University and/or the Bloomsburg University Athletics Department (hereafter BU) to take photographs and/or record video of my minor child/children during his/her/their attendance at a BU Athletic Camp/Clinic. I give BU all rights to use these photographs/videos for advertising and promotional purposes in all conventional and electronic media, as well as any future media. I understand that these photographs/videos will be posted to a camp photo gallery at www.BUcamps.com, but that there is no guarantee that all campers will appear in this gallery.

To protect the privacy of all campers, these photos will not contain any identifying information such as name, address, school currently attending, etc. In addition, photographs/videos will only be taken/recorded in the athletic facilities, and will only be of campers actively engaged in camp activities.

I understand and agree that these photographs/videos may be duplicated, distributed (with or without charge), and/or altered without compensation or liability.

Camper: _____ Parent/Guardian (Print): _____

Parent/Guardian Signature: _____ Date: _____

BLOOMSBURG UNIVERSITY OF PENNSYLVANIA

HUSKIES SUMMER CAMPS

Bloomsburg University Medical Information and Consent for Emergency Treatment

In presenting my son/daughter for diagnosis and treatment, I _____

(Parent or Legal Guardian Name) for_____(Name of son or daughter) with date of birth of _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, and medical treatment by authorized members of the Bloomsburg Hospital Emergency Department or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examination of treatment of my child's condition. I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to Bloomsburg Hospital who will be caring for our (my) child

_____(name of child) for the period _____(camp dates) during _____(sport) camp to arrange emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we/I are responsible for all reasonable charges in connection with care and treatment during this period.

Parent/Guardian Name: _____

Address: _____

_____

Telephone #: _____

Name of health insurance carrier:

_____

Insurance Policy/Group #: _____

Insurance phone #: _____

Family physician: _____

Family physician phone #: _____

Child's allergies, if any: _____

_____

Date of last tetanus booster: _____

Medicine child is taking: _____

_____

Child's past medical history: _____

_____

Current on all immunizations: (circle one) **Yes** **No**

Parent/Guardian Signature: _____ Date: _____

In case of emergency, I can be reached at (phone #): _____

Secondary person of contact is _____ and he/she can be reached at (phone #) _____

****All lines must be filled out in order for the for to be complete, use N/A if not applicable**