



## 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 are (I am) responsible for all reasonable charges in connection with care and treatment during this  
period.

Parent/Guardian Name: _____	Family physician: _____
Address: _____	Family physician phone #: _____
_____	Child's allergies, if any: _____
_____	_____
Telephone #: _____	Date of last tetanus booster: _____
Name of health insurance carrier: _____	Medicine child is taking: _____
_____	_____
Insurance Policy/Group #: _____	Child's past medical history: _____
_____	_____
Insurance Phone #: _____	Current on all immunizations: (circle one) <b>YES</b> <b>NO</b>
Parent/Guardian Signature: _____	Witness Signature: _____
_____	_____
Date: _____	Date: _____

In case of emergency, I can be reached at \_\_\_\_\_  
Secondary person of contact is \_\_\_\_\_ and he/she can be reached at \_\_\_\_\_

**\*\* All lines must be filled out in order for the form to be complete.**

### **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](http://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 Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_