Bloomsburg University
Camp-Clinic On-Site Registration Form

Online registration available 24/7
at www.BUcamps.com

Name_____

DOB_____

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_____

Home ( )_____

Cell ( ) _____

Please Note:

You must also complete the attached medical form and the photo-video release form.

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

Check Number & Last Name: _____ _____

BLOOMSBURG UNIVERSITY™

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 are (I am) 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: _____

Witness Signature:

_____

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, 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: _____