

**OKLAHOMA GOLD WRESTLING CAMP  
CAMPER MEDICAL FORM**

Please complete, SIGN (parent signatures are required) and return this form to:  
Wrestling Office, Athletic Department,  
SUNY Brockport  
350 New Campus Drive, Brockport NY 14420-2989

**PART ONE:**

**CAMPER INFORMATION:**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ AGE: \_\_\_\_\_

**EMERGENCY CONTACTS:**

**This is required information. MUST have a minimum of two (2) Emergency Contacts. Be sure ALL information is CURRENT and ACCURATE. We will assign campus room and phone # at on-campus program registration**

1.) Name of Parent: \_\_\_\_\_ Relation: \_\_\_\_\_

On Campus Room #: \_\_\_\_\_ Day-Time: (\_\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_\_) \_\_\_\_\_

2.) Name of Parent: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Phone #2: \_\_\_\_\_ Day-Time: (\_\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_\_) \_\_\_\_\_

3.) Name of Off Campus contact: \_\_\_\_\_ Relation: -

Emergency Phone #3: \_\_\_\_\_ Day-Time: (\_\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION:**

**This is required information. Be sure ALL information is CURRENT and ACCURATE.**

Name of Medical Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy/I.D.#: \_\_\_\_\_

**PARENT/GUARDIAN STATEMENT:**

I hereby authorize the staff of Oklahoma Gold Wrestling and support staff of SUNY Brockport or any area emergency facility to act for me according to their best judgment in any emergency requiring medical attention for my child.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**This form must be completed in full and submitted prior to the start of camp. If the Camp Medical Director does not receive a COMPLETED Medical Form for your child, your child will NOT be able to attend camp. If you have any questions please call: (585) 395-2498. There are NO exceptions.**

## PART TWO:

**CAMPER MEDICAL HISTORY INFORMATION:**

**This is required information. Be sure ALL information is CURRENT and ACCURATE. Your child's school or family doctor can fax this information to you.**

**1. DATES OF IMMUNIZATIONS: (May attach a copy of records from Doctor's Office)**

___/___/___ Tetanus Booster	___/___/___ DPT Series	___/___/___ Booster
___/___/___ Measles Vaccine (Live)	___/___/___ Polio OPV	___/___/___ Booster
___/___/___ German Measles (Rubella)	___/___/___ TB Test & Result	
___/___/___ Mumps Vaccine (Live)		

**2. NORMAL PULSE RATE:** \_\_\_\_\_ **NORMAL BLOOD PRESSURE:** \_\_\_\_\_

**3. ALLERGIES:**

To What?:	Reaction:	Medication?:
_____	_____	_____
_____	_____	_____

**4. LIST ANY MUSCULAR-SKELETAL INJURIES OR DISEASES. LIST NECESSARY TREATMENT PROCEDURES:**

\_\_\_\_\_  
 \_\_\_\_\_

**5. MEDICATIONS:**

**PLEASE NOTE – If your child will need any form of medication during their stay you MUST provide the medication in the original PRESCRIPTION bottle. If medication is brought in any container other than the original, you will be required to submit a detailed written letter describing the medication, purpose, dosage, timing, and a signed statement that you take FULL responsibility for any problems arising from a lack of proper documentation.**

**I have read the above statement and fully understand. Parent/Guardian Signature:** \_\_\_\_\_

**List ALL medications Camper will be taking during stay (prescriptions, inhalers, aspirin, vitamins, etc.):**

NAME:	DOSAGE:	HOW OFTEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Does Camper administer own medication?**      \_\_\_ YES      \_\_\_ NO

**6. DIETARY INFORMATION:**

**Does Camper have any special dietary requirements?**      \_\_\_ YES      \_\_\_ NO

**If YES, please explain on lines provided below.**

\_\_\_\_\_  
 \_\_\_\_\_

**7. List any information that may assist the Medical Director, physician or nurse in caring for your child:**

\_\_\_\_\_  
 \_\_\_\_\_

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**8. DOCTOR INFORMATION:**

Was a physical necessary to complete the information on this form? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please have the Doctor sign the Physician's Statement:  
I find the above named camper eligible to participate in the Oklahoma Gold Wrestling Camp and activities.

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE PRINT YOUR CHILD'S DOCTOR'S NAME, PHONE, AND FULL ADDRESS:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OFFICE PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ EMERGENCY PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

## PART THREE:

\*REQUIRED\*

### AGREEMENT TO INDEMNIFY AND SAVE HARMLESS

I/we agree to indemnify and save harmless the State of New York, the State University of New York, the State University College at Brockport, Brockport Auxiliary Service Corporation and all its officers and employees from any and all claims, demands, suits, judgments, costs, expenses, actions, and causes of action for personal injury or injuries, death or loss or damage(s) to property sustained by the undersigned participant in the Oklahoma Gold Wrestling Camp sponsored by Jack Spates, at the State University of New York College at Brockport from June 25<sup>th</sup>, 2006 through June 29<sup>th</sup>, 2006, or arising out of any travel to or from, and/or the campus and/or other premises, of the State of New York, the State University of New York, and/or the State University College at Brockport, with particular respect to the Oklahoma Gold program.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Birthdate of Participant

\_\_\_\_\_  
Age

**If the participant has not yet attained the age of 18, both parents and/or participant's legal guardians MUST also sign and date this form.**

\_\_\_\_\_  
Signature of Participant's Father or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant's Mother or Legal Guardian

\_\_\_\_\_  
Date

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