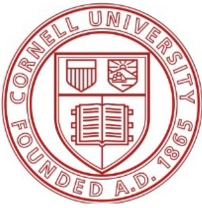

Cornell University
Athletics & Physical Education
Camps & Clinics

Bartels Hall
554 Campus Road
Ithaca, NY 14853
T. 607.255.1200
F. 607.255.2213
camps@cornell.edu
cornellcamps.com

MEDICAL FORM

Sport(s): ____ Camp Dates: ___________________________________
(one form allows camper to participate in multiple camps)

Camper's Name:____ Gender: ☐BOY ☐GIRL DOB:____/____/_______

Primary Contact: ____ Relationship: ______________________________

Work Phone: (______)__________________ Home: (______)_________________ Cell:(______)____________________

Emergency Contact (other):____ Phone: (_____)_______________________

Insurance Co.: ______________________________ Name of Policy Holder: ____________________________________

Policy/ID no.:_______________________________ Insurance Co. Phone: (_____)_________________________

Ins. Co. Address: ____

MEDICAL INFORMATION BELOW - PHYSICIAN'S SIGNATURE REQUIRED**

**You may instead attach a recent copy (within the past year) of a school physical (with physician's signature) if your child has no new medical conditions that limit his or her participation in sport activities. Complete immunization records may also be attached.

MEDICATIONS AT CAMP: Is it necessary to administer medication at camp? ☐YES ☐NO

Medications & Dosages: ____

All medication MUST be in its original container with an accurate pharmacy label. All medications MUST be accompanied by physician's orders, including over-the-counter medications. All medication MUST be given to the Medical Director at check-in.

Allergies to Medications: ____

Medical conditions, even if controlled (diabetes, seizures, etc.) ____

____

Date of most recent immunizations: Tetanus _______ Measles _______ Mumps ________ Rubella ________ Diptheria ________

Poliomyelitis ________ Hemophilus influenza type b ________ Hepatitis b________ Varicella (chicken pox) ________

I have examined _____________________________________ and hereby certify that s/he is able to participate in athletic activities.

____ ____________ (______)_________________________
Physicians Signature Date Phone

MEDICAL TREATMENT AUTHORIZATION (Must *always* be signed by parent and by camper *if* camper is 18 years of age or older)

I give my permission for my daughter/son/ward to receive medical care by the staff of Gannett Health Services and Cayuga Medical Center at Ithaca (including its Convenient Care Center) in the event of injury or illness. I also give permission for medical staff to administer any medications as indicated above. In addition, I consent to have Gannett Health Services use and disclose my daughter/son/ward protected health information for payment, treatment, and health care operations purposes. Protected health information means health, billing, and demographic information created or received by Gannett Health Services. In the event that Gannett Health Services participates with my health insurance, I authorize the payment of benefits to Gannett Health Services. I understand I will be responsible for all charges for health services provided by Gannett Health Services and by off-campus providers in the event that they do not participate with my health insurance.

PRIVACY INFORMATION: Gannett Health Services has a long-standing commitment to the rights and privacy of it patients. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers to inform patients and/or parents of minors of their Notice of Privacy Practices. I acknowledge that I have been made aware of Gannett's Notice of Privacy Practices, which can be reviewed at www.gannett.cornell.edu.

Parent/guardian Signature: ______________________________ Camper Signature (if 18 or older) ___________________________

Date: Date: