



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 Cornell 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 Cornell 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 Cornell Health Services. In the event that Cornell Health Services participates with my health insurance, I authorize the payment of benefits to Cornell Health Services. I understand I will be responsible for all charges for health services provided by Cornell Health Services and by off-campus providers in the event that they do not participate with my health insurance.

PRIVACY INFORMATION: Cornell Health Services has a long-standing commitment to the rights and privacy of its 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 Cornell's Notice of Privacy Practices, which can be reviewed at www.health.cornell.edu.

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

Date:

Date: