



MEDICAL, HEALTH, AND WAIVER FORM

Participant's Name (please print)		Age	Birthdate	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (include city and zip)		Day Phone () -		
		Evening Phone () -		
Names of custodial parent/guardian(s)		Email		
Emergency Contact Name (1)	Day Phone ()	Evening Phone ()	Cell Phone ()	
Emergency Contact Name (2)	Day Phone ()	Evening Phone ()	Cell Phone ()	

HEALTH HISTORY: This information must be filled in. Complete the form in detail so we can be aware of the participant's needs.

Please note any health problems the participant may have experienced or been exposed to in the month prior to camp:

Has/does the participant:	Yes	No		Yes	No
Ever have bleeding / clotting disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Have current sleep walking condition?	<input type="checkbox"/>	<input type="checkbox"/>
Have convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Have hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Ever have chronic ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
Have heart defects / hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to iodine?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had psychiatric treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to latex?	<input type="checkbox"/>	<input type="checkbox"/>
Have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to bee stings?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seasickness?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had poison oak?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>	Have any physical impairment?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had joint problems?	<input type="checkbox"/>	<input type="checkbox"/>	Wear contact lenses or glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Have current bed wetting condition?	<input type="checkbox"/>	<input type="checkbox"/>	Other? (please list)	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any Yes items checked:					

Explain any activity restrictions:

Are there any special needs that would be helpful for us to know about?

MEDICATION On an index card list **all** medications taken routinely, dosage, and frequency of administration (over-the-counter and prescription drugs). Bring enough medication to last the entire program. Place it in one zip closed bag in the original packaging, that identifies the prescribing physician, and medication name. All youth medications will be administered by a supervising adult.

<input type="checkbox"/> This person takes no medications on a routine basis.
<input type="checkbox"/> This person takes medications as follows:
Med #1 _____ Dosage _____ Specific time taken each day _____
Med #2 _____ Dosage _____ Specific time taken each day _____
Med #3 _____ Dosage _____ Specific time taken each day _____
Does this person carry: An Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No An Epi-pen? <input type="checkbox"/> Yes <input type="checkbox"/> No

Non-Prescription Medications: I authorize the following medications to be administered as needed:

- Tylenol Yes No Benadryl Yes No Tums Yes No Sudafed Yes No
Chloraseptic Yes No Cough Drops Yes No Ibuprofen Yes No Calamine Lotion Yes No

HEALTH QUESTIONNAIRE:

List any allergies (Food, Medications, etc)

Dietary Restrictions:

No meat Nut Allergy Seafood Allergy
I eat: Chicken Pork Beef

Name of Physician:

Physician's Address:

Does the participant
carry medical
insurance?

Carrier:

Telephone:

Yes No

Policy #:

Last Physical Examination:

WAIVER: Please review, initial, and check one box in each of the following sections. When complete, please sign at the **X** at the end.

A. AUTHORIZATION FOR TREATMENT: As parent/guardian, I certify that my child is in excellent health and has no physical, mental, or emotional problems which are likely to prevent participation in strenuous physical activity. I give permission for participant to be medically treated for illness occurring or injury sustained during such participation. I certify that I have completed the Health History questionnaire fully and accurately and accept full responsibility for any errors or omissions. I have read the foregoing and fully understand it.

I agree I disagree Initial: _____

B. PHOTOGRAPH/INTERVIEW AUTHORIZATION: I agree that any photographs and videos taken by any Camp SEA Lab personnel shall be the property of Camp SEA Lab, and may be used by Camp SEA Lab, at its discretion, for any publicity, marketing, social web media and/or advertising purposes, and I hereby consent to and authorize such use without restriction. I also give permission for my child to be interviewed about Camp SEA Lab by the news media.

I agree I disagree Initials: _____

C. WAIVER OF LIABILITY, INDEMNIFICATION, AND HOLD HARMLESS AGREEMENT

1. In consideration of being allowed to participate in **Camp SEA Lab** I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE THE STATE OF CALIFORNIA, THE TRUSTEES OF THE CALIFORNIA STATE UNIVERSITY, CALIFORNIA STATE UNIVERSITY MONTEREY BAY, FOUNDATION OF CALIFORNIA STATE UNIVERSITY MONTEREY BAY, AND THEIR OFFICERS AND EMPLOYEES (hereinafter collectively referred to as the "RELEASEES") from any and all liabilities, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by participant, or to any property belonging to me or participant, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in such activity, or while in, on, or upon the premises where the activity is being conducted.

2. I am fully aware of risks and hazards connected with the activity of **Camp SEA Lab**, the risk of which may include but are not limited to risks associated with water activities, hiking, tide pooling, beach clean-up activities, and transportation to and from sites, and I hereby elect and/or elect participant to voluntarily participate in said activity, and to enter the above-named premises and engage in such activity knowing that the activity may be hazardous to participant and participant's property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by participant, or any loss or damage to property owned by me, as a result of being engaged in such an activity, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise.

3. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEES from any loss, liability, damage, or costs, including court costs and attorney's fees, that they may incur due to my or participant's participation in said activity, WHETHER CAUSED BY NEGLIGENCE OF RELEASEES or otherwise.

4. It is my express intent that this Medical, Health, and Photo Registration Form and this section's Waiver of Liability, Indemnification, and Hold Harmless Agreement shall bind the members of my and participant's family and spouse, if I am or participant is alive, and my and participant's heirs, assigns, and personal representative(s), if I am deceased and/or participant is, and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Medical, Health, and Photo Registration Form and this section's Waiver of Liability, Indemnification, and Hold Harmless Agreement shall be construed in accordance with the laws of the State of California.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Medical, Health, and Photo Registration Form and Waiver of Liability, Indemnification, and Hold Harmless Agreement, understand the terms, and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made. As parent/guardian, I certify that participant is in good health and has no physical, mental, or emotional problems which are likely to prevent participation in strenuous physical activity. I give permission for participant to be medically treated for illness occurring or injury sustained during such participation and certify that he/she is covered by medical insurance.

X

Signature of Participant or Parent / Guardian of Participant Date

Name of Parent/Guardian (please print)