Mid American Pompon
All Star Team
Medical and General Information Sheet

Please fill out completely; for some events, specific information is required.

First Name: _____ Middle: _____ Last: _____

School: _____ Grad Year: _____

Date of birth: Month _____ Day _____ Year _____

Parent or Guardian: _____

Home Phone Number ( ) _____

All Star Cell Phone Number ( ) _____ N/A
May be used by event director when traveling

Parent Cell Phone Number ( ) _____ N/A

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Additional Emergency Contact Person: _____

Relation to All Star: _____

Phone Number ( ) _____

Are you are you a United States Citizen? YES NO

Is the medical release submitted for Mid American Summer Camp 2008 is up to date? YES NO
(Please contact Mid American if "NO", or if info changes throughout the year)

An attempt will be made to notify the Parents if the Participant requires medical treatment outside of camp as quickly as is reasonably possible under the particular circumstances. IN CASE OF EMERGENCY, Parents hereby give permission to transport or arrange for the transport of the Participant to the nearest hospital for emergency treatment, where participant may receive emergency care upon recommendation of a qualified physician. Parents and Participant also authorize MAP to use the likeness of the Participant in promotional materials and/or media.

Further, Parents and Participant must provide the following information:

Is Participant taking any prescriptions or over the counter medicine at present? Please state reason:

_____
_____
_____

List all prescriptions and over the counter medications. MAP is hereby directed to allow the Participant to take medications as directed by the Parents and Participant's physician. Parents and/or Participants must bring medications in original containers with name, content, unit dose, directions, plus prescribing physicians name and phone. These instructions must accompany each medication brought to the Activities. MAP will dispense the medication brought for the Participant, plus aspirin, non-prescriptive pain reliever and cough syrup upon the Parents' written request only and following the written instructions of the Parents.

List current medications and directions:

_____
_____
_____

ANY allergies and reactions (medication, food, bee sting, etc.):

_____
_____

Does Participant require a medically prescribed diet? YES NO
If yes, please explain

_____
_____

Any illness, injury, physical limitations, absence of organ, etc. that has occurred:

_____
_____

Has Participant ever "passed out" or been "knocked unconscious" (concussion) or experienced seizures of any type? Please describe:

_____
_____

THE ABOVE INFORMATION WILL BE KEPT STICTLY CONFIDENTIAL. PLEASE FEEL FREE TO ASK QUESTIONS AT ANY TIME. THANK YOU FOR PROVIDING VALUABLE INFORMATION FOR YOUR CHILD'S WELL-BEING! POMPON PARTICIPANTS WHO NEED TO BE TAPED DAILY, SHOULD BRING TAPE AND PRE-WRAP FOR OUR ATHLETIC TRAINERS. BEE STING KITS SHOULD BE CARRIED AT ALL TIMES BY THOSE STUDENTS WHO ARE HIGHLY ALLERGIC.

I AGREE TO THE POLICIES AND PROCEDURES STATED ABOVE. I UNDERSTAND, AS IN ANY PHYSICAL ACTIVITY, THERE ARE RISKS INVOLVED. I agree to indemnify and hold harmless Mid American Pompon and their employees from all claims, damages, losses, injuries, and expenses arising out of or resulting from participation in these activities.

_____ _____
Participant Signature Date Parent or Guardian Signature

_____ _____
Heath Care Provider Name on Card

_____
Heath Care Policy Number