Application Number: _____ **Paid Via:** **Money Order#** _____ : **Cash** _____ : **Credit Card:** **Visa** **or** **MC**

USC TROJAN KIDS CAMP (June 19th – July 14th 2017)

SPONSORED BY: USC RECREATIONAL SPORTS

2017 Parent/Guardian Consent Form

_____
Participant's Last Name First Name Middle Initial

_____
Street Address City State Zip

(_____)_____ (_____)_____ E-mail: _____@_____
Home Phone Work/Cell Phone

Sex (circle one): Male Female Age: _____ Birth date (mm/dd/yy):_____

Ethnicity: _____ **T-Shirt Size:** (Youth *M-XL) _____ **or** (Adult S-XL) _____

Name of school: _____

Years in USC **Trojan Kids Camp** (circle one): first time 1 yr 2yrs 3yrs 4yrs 5yrs 6yrs

For emergencies during camp hours, 8:30am – 4:00pm, please contact:

_____ (_____)_____ _____
Name Home, Work or Cell Phone Relation to child

_____ (_____)_____
Name of family doctor/clinic to contact for medical care Phone of doctor/clinic

A. List any allergies: _____
B. List medications (including asthma medication) your child takes regularly, if any, and for what purpose:
_____

NOTE: Your child MUST have necessary medication with them while attending camp. Please contact camp office for administering instructions.

C. Can your child take any of the age-appropriate medications? (circle Yes or No)
Aspirin: Yes/No **Tylenol**: Yes/No **Antacids**: Yes/No **Motrin**: Yes/No **Benadryl**: Yes/No

Medical: (See medical exam form on reverse side) I give my permission for treatment in case of illness or accident while participating in the USC **TROJAN KIDS CAMP** program. I understand and wish that said doctor or hospital will administer whatever emergency treatment is deemed necessary until I can be reached.
_____ **Parent/Guardian Initials**

Field Trips: I agree to permit my child to take part in all USC **TROJAN KIDS CAMP** field trips, understanding that these may involve transporting my child off campus. _____ **Parent/Guardian Initials**

Release of Liability: I agree that the USC **TROJAN KIDS CAMP** staff and/or the University of Southern California shall not be held liable or responsible in any way for any loss of materials or injuries to my child arising from the USC **TROJAN KIDS CAMP**. I certify that all the above information is true and accurate. If any information is misstated or falsified, I understand that this application may be denied.

_____ _____
Print name of Parent/Guardian **Signature of Parent/Guardian** **Date**

_____ _____
Relationship to Child **Phone**

Application Number: _____

TO BE COMPLETED BY A PHYSICIAN ONLY
USC TROJAN KIDS CAMP Medical Examination Record
Valid for TROJAN KIDS CAMP Participation Only

Name: _____ _____
Last Name **First Name**

Date of Birth: _____/_____/_____ Sex: M F Height: _____ Weight: _____

Temperature: _____ Pulse: _____ Blood Pressure: _____/_____

Vision w/o glasses: (R) _____ (L) _____ Asthma: Yes No (Circle one)

Date of last tetanus shot: _____ Hemophilia: Yes No (Circle one)

	Normal	If abnormal, describe here	Follow-up Yes No
Ears (hearing absence or cerumen)			
Eyes (reflexes visual acuity)			
Nose, Throat, Sinuses			
Neck			
Lungs			
Breasts			
Lymph Nodes			
Heart			
Abdomen			
Hernia			
Back			
Skin			
Bones, Joints and Muscles			
Nervous System			
Teeth and Gums			

- General Physical Condition: _____
- **May participate in USC TROJAN KIDS CAMP Program: (circle one) Yes No**
- Additional comments or recommendations: _____

_____ _____ _____
Signature of examining physician **Stamp** **Date**

_____ _____
Print Name of examining physician **Examining physician phone**