

Name of Event

Parental Authorization

All information on this form **MUST** be completed to guarantee a place in the camp.

Camper Name _____

Address _____

City _____

State _____ Zip _____

Home Phone (_____) _____

Parent E-mail _____

Grade (Fall 2008) _____ Age (at time of camp) _____

Gender: Male Female

Printed Name of Legal Guardian _____

Roommate Name _____
(Must be mutual. Applications must be returned together.) I require auxiliary aids/services due to a disability.
Please contact me at the above address.**T-Shirt Size**Adult: S M L XL Youth: S M L**Interest Questions** If you have any additional questions for attendees.
Fees Registration \$XXX
 Registrations received after X Date, add \$XXX
Total Enclosed \$ _____**Payment Method**

Payment is required upon submission of registration.

 Enclosed is a check payable to **Purdue University**. Please charge to my:
 VISA American Express Discover MasterCard

Account Number _____

Expiration Date _____

Authorized Signature _____

Printed Name _____

Please mail with payment to:

CEC Business Services
Purdue University
Stewart Center, Room 110
128 Memorial Mall
West Lafayette, IN 47907-2034

or fax your with credit card information to: (765) 494-0567

Registration is complete with submission of Parental Authorization Form, full payment, and a complete registration form.

Please photocopy this form for additional registrants.

PURDUE UNIVERSITY MEDICAL AUTHORIZATION FOR TREATMENT OF A MINOR

(persons under 18 years)

Pursuant to Indiana Code Paragraph 16-36-1-6, I request and authorize the Purdue University Student Health Center, Purdue University Ambulance Service, Home Hospital, and St. Elizabeth Hospital medical personnel, agents, and employees to provide all reasonably necessary medical care advisable for the health of my child, including but not limited to medical transport, hospital tests, such as pathology, radiology, anesthesia, evaluation and treatment by physicians, including surgery, and prescription drugs. I acknowledge that no representations, warranties, or guarantees can be made with respect to any medical care or treatment provided.

I also understand that, as a result of my child's participation in this program, it will be necessary for supervisors, coaches, residence hall personnel, and others involved with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

Further, I hereby grant permission for my child:

(minor's name)to attend the **Name of Event** by signing below. **A signature from one or both parents/legal guardians and a witness signature are required.**_____
Signature Parent/Legal Guardian (required)_____
Signature Parent/Legal Guardian/Witness (required)

PHYSICIAN APPROVAL

I have examined _____

and found him/her to be healthy to participate in general recreational activities of his/her choosing during the **Name of Event**.

Medical Conditions _____

Current Medications _____

Allergies _____

Date of Last Tetanus Shot _____

(If date not supplied, child may be required to obtain a tetanus shot if injured.)

Physician's Signature _____

Phone _____

EMERGENCY CONTACT

Contact First - Name _____

Relationship to Participant _____

Day Phone _____

Night Phone _____

Contact Second - Name _____

Relationship to Participant _____

Day Phone _____

Night Phone _____