TEAM PARTICIPATING WITH:_____ or INDIVIDIAUL_____

2022 Connecticut Field Hockey Camp, LLC

7v7 Clinic/Tournament:

Youth Program Consent for Treatment Waiver

This form must be completed and returned before the youth camp/program/event enrollment dates in order for your youth to be permitted to participate in any program activities. By mail to: Connecticut Field Hockey Camp, LLC: PO Box 728, Storrs, CT, 06268 or presented at registration.

PERSONAL INFORMATION:

Youth's Last Name:_____ First Name:_____ Birthdate:_____ ☐ Female ☐ Male

Specify program your child will be attending: ☐ June 11: U12 ☐ June 11: U14 ☐ June 12: U16 ☐ June 12: U19 ☐ ☐ ☐ ☐

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ E-mail Address:_____

Parent/Guardian # 1:_____ Parent/Guardian # 2:_____

Daytime Phone:_____ Daytime Phone:_____

Place of Employment:_____ Place of Employment:_____

Health Insurance Carrier:_____ Policy #:_____

Plan #:_____ Is your physician authorization needed ☐ Yes ☐ No

Name of Physician:_____ Phone:_____

In case of emergency, please notify:

1._____ Phone:_____

2._____ Phone:_____

HEALTH HISTORY:

Allergies:

☐ Hay Fever ☐ Bee/Wasp stings ☐ Insect Stings ☐ Penicillin ☐ Peanut ☐ Other Food/Drugs:_____

Other:

☐ Asthma ☐ Diabetes ☐ Convulsions ☐ Behavioral/Emotional ☐ Other:_____

Date of most recent tetanus immunization:_____

Please list any major past illnesses (contagious and non-contagious):_____

Please list any major operations or serious injuries (include dates):_____

Has the youth ever been hospitalized? ☐ No ☐ Yes if YES, explain:_____

Does the youth have any chronic or recurring illness? ☐ No ☐ Yes if YES, explain:_____

Is there anything else in the youth's health history that the program staff should know?_____

Are there any activities from which the youth should be restricted? ☐ No ☐ Yes if YES, explain:_____

Are there any specific activities that should be encouraged? ☐ No ☐ Yes if YES explain:_____

Does the youth have any special dietary restrictions? ☐ No ☐ Yes if YES, explain:_____

_____

Does the youth wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? ☐ No ☐ Yes if YES, explain:_____

_____

Will the youth need to take any medication during the program? ☐ No ☐ Yes

IF YES, please list the specific prescription or over-the-counter medications below, reasons for medication, and daily dosage. If any medications change prior to arriving at the program, please provide an updated list upon arrival.

Medication	*Reason(s) for Medication*	*Daily Dosage/Time(s) Taken*
1.		
2.		
3.		
4.		

If at all possible, medication should be administered at home. Medications will be allowed at the Youth Program only when failure to take such a medication would jeopardize the health of the child and he/she would not be able to attend the Youth Program if the medication were not made available

Youth's Last Name:_____ First Name:_____Birthdate:_____ ☐ Female ☐ Male

HEAD INJURY:
Connecticut Field Hockey Camps staff will manage head injuries, including suspected concussions, conservatively using 'ABC' (A-Assess the situation, B-Be alert for signs & symptoms, C-Contact a health care professional) recommendation of the Centers for Disease Control and Prevention (CDC).
This includes immediate removal of a camp/clinic participant from play upon sustaining a head injury and using appropriate field clinical techniques to screen the participant for typical signs and symptoms associated with a concussion. Upon presenting with any associated signs and symptoms of a concussion, the Sports Health Care Staff will advise a parent/legal guardian/coach that the respective participant discontinue play immediately.

Connecticut Field Hockey Camps adheres to the notion that a licensed physician with training in managing traumatic brain injury will make the final recommendations and decision regarding returning a participant to play after a head injury with suspected concussion. Thus, Sport Healthcare personnel will NOT make such decisions.

I understand that all Youth Program Participants are recommended to have a meningococcal vaccination prior to attending the program.

I hereby authorize the clinical staff at Connecticut Field Hockey Camp, LLC or other licensed health care practitioners, acting within the scope of his or her practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor daughter/son/dependent. I understand that the consent and authorization here in granted does not include major surgical procedures and is valid only during the Youth Program/Event.

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for Connecticut Field Hockey Camp, LLC staff or licensed health care practitioners to perform any necessary emergency treatment.

I agree to the release of records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. If treatment is provided by Connecticut Field Hockey Camp, LLC, I understand there may be charges for services and that it is my responsibility to pay the bill. I may be responsible to submit any claims to my health insurance carrier for reimbursement. I also authorize Connecticut Field Hockey Camp, LLC to receive medical/billing information and submit it to their insurance carrier.

I understand that, unless specifically stated otherwise in Connecticut Field Hockey Camp, LLC/event literature, Connecticut Field Hockey Camp, LLC does not provide medical insurance to cover emergency care or medical treatment of my child.

I understand that, in accordance with Youth Program policy, any medication(s) should be given at home and/or after the Youth Program. However, when this is not possible, and medication will be brought to the Youth Program event, I agree to the provisions outlined above relating to the management of medications.

MEDICAL and RELATED HEALTH INFORMATION Connecticut Field Hockey Camp, LLC is committed to protecting the medical and related health information about your child. Medical and related health information provided on this form will only be used as Connecticut Field Hockey Camp, LLC deems necessary to provide services for your child while participating in the Youth Program. Information will be stored, archived and disposed of accordingly per State of Connecticut regulations.

RELEASE OF LIABILITY AND MEDIA PERMISSION
I, the undersigned, as a parent/gurardian of the above identified youth, a minor, ask that he/she be admitted to participate in this Youth Program sponsored by Connecticut Field Hockey Camps, LLC. In consideration of such admission, I do hereby agree to release, discharge, and hold harmless Connecticut Field Hockey Camps, LLC and the University of Connecticut, its officers, agents, and employees of and from all causes, liabilities, damages, claims, or demands whatsoever on account of any injury or accident involving the said minor arising out of the minor's attendance at the sports camp/clinic or residence of University Housing, or in the course of competition and/or activities held in connection with the sports camp/clinic.

Additionally, I authorize this Connecticut Field Hockey Camp, LLC to photograph, videotape, and/or audiotape my child in promotion of the Connecticut Field Hockey Camp, LLC's youth program.

_____

Parent/Legal Guardian Name (PLEASE PRINT) Parent/Legal Guardian Signature

_____

Date *Terms and Conditions agreed to via electronic signature

Revised December 2021