THIS FORM MUST BE PRESENTED AT REGISTRATION

DAYTON WOMEN'S BASKETBALL CAMP

Medical Release Form

Last Name First Name Middle Name

Street Address Age

City State Zip

Parent of Guardian Home Phone Work Phone

DO YOU HAVE ANY ALLERGIES (including medication) _____Yes_____No
If so, list:

ARE YOU PRESENTLY TAKING ANY MEDICATION? _____Yes_____No
If so, list:

DO YOU HAVE ANY SIGNIFICANT HEALTH PROBLEMS? _____Yes_____No
If so, list:

PHYSICAN'S NAME PHYSICAN'S PHONE

I authorize the University of Dayton athletic trainer, a member of the athletic trainer's staff, the staff of the University of Dayton Student Health Center and/or any other medical facility designated by said persons to provide necessary medical services for treatment of illness or injury, including diagnostic procedures such as laboratory tests and x-rays to:

Name of Participant

I understand that I will be notified in case of serious illness or injury, or if surgical treatment is necessary.

Signature of Parent or Guardian