

EPSILON OMEGA MEN FOUNDATION, INC. BOYS CAMP
Medical, Consent Forms and Releases

Name of Applicant: _____
LAST FIRST MIDDLE INITIAL

Home Address: _____ City _____
State Zip

Sponsoring Chapter/address _____

Responsible Party in Chapter: Name _____ Title _____
 Address _____ City _____ State _____ Zip _____
 Telephone: Home () _____ Business () _____

MEDICAL EXAMINATION		*Date of Examination _____	
Doctor's Physical Examination		Applicant's Date of Birth _____	
Height _____	Weight _____	Blood Pressure _____	
	NORMAL	ABNORMAL	COMMENTS
Eyes	_____	_____	_____
Ears	_____	_____	_____
Nose, Throat	_____	_____	_____
Heart, Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Extremities	_____	_____	_____
Neurological	_____	_____	_____
Allergies to Medication: _____ yes _____ No If yes, please list:			
Restrictions: _____			
Physician's NAME (print) _____			
ADDRESS: _____		CITY _____	
STATE _____		ZIP _____ PHONE () _____	
Physician's Signature _____			

Parent/Guardian (NAME): _____ PHONE: H () _____
 ADDRESS: _____ CITY _____ B () _____
 STATE _____ ZIP _____

(*Examination must not have been given more than six months prior to activity.
 Date(s) of activity is/are _____.)

Emergency Contact, if parent/guardian not available:

Name: _____ Address: _____
 State _____ Zip _____ Phone H. () _____ B. () _____

Name: _____ Address: _____
 State _____ Zip _____ Phone H. () _____ B. () _____

Family Doctor: Name _____ Phone () _____
 ADDRESS: _____ CITY _____ STATE _____ ZIP _____
 Medical Insurance Policy Name: _____ Policy # _____

To be answered by parent or guardian:

(CIRCLE ONE)

DOES YOUR CHILD HAVE OR HAS HE EVER HAD:

- | | | |
|---|-----|----|
| 1. Sickle Cell Anemia? | YES | NO |
| 2. Food/medication allergy? | YES | NO |
| 3. Epilepsy, seizures, fainting spells?..... | YES | NO |
| 4. Heat stroke or heat exhaustion? | YES | NO |
| 5. Diabetes mellitus (sugar) or juvenile diabetes?..... | YES | NO |
| 6. Hemophilia (bleeding disorder)?..... | YES | NO |
| 7. Bone or joint problems? | YES | NO |
| 8. Heart problem? | YES | NO |
| 9. Hearing or vision problem?..... | YES | NO |
| 10. Eye glasses, contact lens?..... | YES | NO |
| 11. Dentures or hearing aid? | YES | NO |
| 12. Loss of function of a bodily part? | YES | NO |
| 13. Require a special diet?..... | YES | NO |
| 14. Special psychiatric conditions (Schizophrenia or Depression)? | YES | NO |
| 15. High blood pressure, hypertension? | YES | NO |

If the answer to any of the above is "Yes," explain fully below. Give details as to when the event occurred, your child's current status and any special needs that he now has.

Medications:

	NAME	EXACT DOSAGE	SPECIFIC TIME GIVEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Allergies:

List: _____

Tetanus Booster:

Date: _____

PARTICIPATION/MEDIA RELEASE

I hereby give my permission for (child's name) _____ to participate in the Epsilon Omega Men Foundation, Inc. Summer Boys Camp activities and events. I also grant to the Epsilon Omega Men Foundation, Inc. permission to record my child/ward's likeness and/voice for use by television, films, radio or printed media to further the aims of the Epsilon Omega Men Foundation, Inc. in related campaigns, magazine articles, booklets, posters, and in other ways it sees fit. I hereby release Epsilon Omega Men Foundation, Inc., its insurer, agents, heirs, successors and assigns from any and all liabilities and claims in connection herewith.

CONSENT TO TREATMENT/EVIDENCE OF INSURANCE

In the event that my child/ward should for any reason require any minor or surgical treatment and/or medication during the course of his attendance at or participation in the Epsilon Omega Men Foundation, Inc. activities, I authorize such physician or emergency care staff that the Epsilon Omega Men Foundation, Inc. may appoint or designate to carry out the necessary treatment, or to take my child/ward to the emergency room of any hospital, and I further authorize the hospital and its medical staff to provide the treatment deemed necessary by them for the well being of my child/ward. It is understood, however, that if hospitalization or treatment of a more serious nature is required, I will be contacted, if at all possible, by telephone for permission.

I the undersigned, am a parent (or legal guardian) of the above specified child. I have read and fully understand the provisions of the above releases and have explained them to said minor. I further declare that all of the statements that I have made herein are true to the best of my knowledge, information and belief. I hereby agree on behalf of myself and my child/ward to hold harmless and release the Epsilon Omega Men Foundation, Inc., the attending physician(s), hospital, their insurers, agents, heirs, successors, and assigns from any and all liabilities and claims arising out of any treatment rendered to my child/ward.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____