Stony Brook University

Assumption of Risk and Insurance Policy Statement
for participation in camp and sports clinic activities at SUNY Stony Brook

I understand and agree that the participation of my son/daughter in any camp or sports clinic held at the State University of New York (SUNY) at Stony Brook (Stony Brook University) is voluntary.

I further understand and agree that Stony Brook University, the State University of New York or the State of New York is not liable for any injury, damage, or other loss which my son/daughter may cause or incur, or may cause others to incur, while using Stony Brook University facilities or equipment, or while participating in any camp or clinic provided by Stony Brook University and/or its affiliates.

I am aware that SUNY, the State of New York and Stony Brook University DO NOT carry insurance coverage for any injury or damage that my son/daughter might cause or incur while using Stony Brook University equipment or facilities.

I have insurance coverage for and specifically assume responsibility for all risks, injuries, damages, or other losses that my son/daughter might cause or incur while using any University equipment and/or facilities at Stony Brook University, or while participating in any program, exercise or activity at Stony Brook University or on Stony Brook University premises.

Note: Campers who do not have this form completed by the start of the camp/clinic session **will not be permitted to participate** in any/all camp/clinic related activity until this form is completed and returned.

_____	_____
Camper Name	Camp/Clinic Name
_____	_____
Parent/Guardian Name	Daytime Phone Number
_____	_____
Cell Phone Number	Evening Phone
_____	_____
Insurance Policy Carrier	Policy Number
_____	_____
Parent/Guardian signature	Date

STONY BROOK UNIVERSITY
Medical History Form

Name of Camp/Clinic: _____

Dates of Camp/Clinic Attending: _____

Personal Information

Name of Camper: _____ Sex: M F Birthdate: _____

Name of Parent: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

Family Physician: _____ Phone Number: _____

Name of Person to contact in an emergency: _____

Relation to camper: _____ Daytime Phone Number: _____

Cell Phone Number: _____

Authorization for Medical Care

I hereby authorize a Staff member from Stony Brook University Athletics Department to be responsible for my son/daughter, _____, for the purpose of medical attention. I also grant permission for an emergency physician to examine and treat, hospitalize or secure treatment for my child in the event of an emergency.

Parent/Guardian Signature: _____ Date: _____

Assumption of Risk Statement

I have registered my child, _____, for *The Summer Camps at Stony Book University*. I am fully aware of the actual and potential risks of personal injury (including serious injury and death) inherent in this activity. By signing below, I am asserting that I knowingly and voluntarily assuming all such risks for my child as well as medical expenses incurred as a result of injury or illness to my child. I am aware that *The Summer Camps at Stony Brook University* supplies an EXCESS ONLY policy and will cover, within the limits of the policy, any outstanding or denied bills.

Summer Camp Insurance Policy Summary

Please be advised that The Summer Camps insurance is a secondary carrier. The insurance plan pays the medical expenses actually incurred by an insured person when an accidental injury occurs while in attendance at the camp. This coverage is excess coverage and begins after the exhaustion of all other coverage for which the participant may be eligible. Should you have any questions please contact the Stony Brook Camp Office coordinator or director.

Medical History

Is child in good health: Yes No If not, please explain: _____

_____

Should nature or amount of physical exercise be limited: Yes No If so, please explain: _____

_____

Does child have any allergies: Yes No If so, please explain: _____

_____

Is child taking any medications regularly: Yes No If so, please explain: _____

_____

PROOF OF IMMUNIZATIONS ~ MUST BE COMPLETED BY YOUR PHYSICIAN'S OFFICE
NEW YORK STATE LAW REQUIRES ALL DATES FOR IMMUNIZATIONS

Dates Dates

Diptheria/Tetanus/Pertussis (DTP) _____ Poliomyelitis (IPV) _____
Measles/Mumps/Rubella (MMR) _____ Varicella (Chicken Pox) _____
Haemophilus Influenzae Type (Hib) _____ Hepatitis B _____
Pneumococcal Conjugate (PCV) _____

Physician's office verification of immunization:
(Please use office stamp or have physician sign) _____ Date: _____