

THIS FORM IS TO BE COMPLETED FOR ANY CONFERENCE PARTICIPANT UNDER THE AGE OF 18. PLEASE NOTE: CONFEREES MAY NOT UTILIZE OUR HEALTH CENTER FACILITY WITHOUT THIS COMPLETED FORM.

DORM ROOM # _____ **KUTZTOWN UNIVERSITY**
OFFICE OF CONFERENCE SERVICES
HEALTH HISTORY/MEDICAL TREATMENT PERMISSION FORM

Name: _____ **Birth date** _____ **Sex** _____ **Age** _____

Parent or Guardian _____

Home address _____ Phone _____

Business address _____ Phone _____

Other Emergency Contact _____

Home address _____ Phone _____

Business address _____ Phone _____

Name of conference: **BIG KICK SOCCER CAMP** _____ Date: **June 15-19, 2008**

Health History: (give dates)	Diseases: (give dates)	Allergies: (give dates)
Heart Defect/Disease _____	Chicken Pox _____	Hay Fever _____
Convulsions _____	Measles _____	Ivy Poisoning _____
Diabetes _____	German Measles _____	Insect Stings _____
Hypertension _____	Mumps _____	Penicillin _____
Mononucleosis _____		Other drugs _____
Bleeding/Clotting Disorder _____		Asthma _____
Frequent Ear Infections _____		

Operations or serious injury (dates): _____

Disability or chronic recurring illness: _____

Dietary modifications: _____

Current medication taking: _____

Do you carry family medical/hospital insurance? _____ Carrier _____ # _____

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter, named above, to attend the conference named above. In order that my son/daughter may receive the proper medical treatment in the event that he/she may sustain injury or illness during the period of the above conference, I hereby authorize the conference staff and the Kutztown University Health Center to obtain or provide medical treatment for my son/daughter for such injury or illness during the conference, and I hereby hold the University, as well as its representatives, harmless in the exercise of this authority.

I further understand that there is always a possibility that my son/daughter may sustain physical illness or injury while at a conference at Kutztown University. If this occurs, I hereby authorize conference staff and Kutztown University Health Center and Kutztown University representatives to refer my son/daughter to a medical treatment center (hospital, etc.). I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter for physical illness or injury that he/she may sustain during the conference.

Understanding that there is always a possibility that my son/daughter may sustain physical illness or injury, I acknowledge and understand that my son/daughter is assuming the risk of such physical illness or injury by his/her participation, and I further release Kutztown University Foundation and its representatives and Kutztown University and its representatives from any claims for personal illness or injury that my son/daughter may sustain during the conference. I further acknowledge and understand that my son/daughter will be responsible for his/her failure to abide by the rules and regulations of the conference named above or of Kutztown University. I also give permission to Game Face International, LLC to use my photograph and/or video for any current and future promotional materials.

Signed _____ Date _____ Phone _____

**THIS FORM MUST BE RETURNED TO THE GAMEFACE OFFICE
 904 PENN AVE. Suite 2 WYOMISSING, PA 19610 FAX # 610-927-6298**