Doug Karleskint Basketball Camps

Medical Treatment Consent Form

____Age____________

(Print Full Name of Minor)

Social Security Number (If Available) _________ - _________ - _________, will be attending the Doug Karleskint Basketball Camp on the campus of The University of Central Missouri on ______________________. I or assigned chaperones give permission to the Doug Karleskint Basketball Camp to act on my behalf for the above minor in granting permission for evaluation/treatment of minor medical problems.

I understand that should a major medical problem arise, I will be notified by telephone. In the event that I cannot be reached, I hereby give my consent to such medical treatment deemed necessary, including x-ray examinations and anesthesia to be rendered to said minor by a licensed physician or licensed physicians.

I hereby certify I have read and fully understand this authorization.

____ ____________________

(Signature of Parent/Guardian) (Date)

Telephone:_______________________________/_________________________________

(Home) (Work)

Address:____

(Street) (City, State, Zip)

Please provide the following information concerning your camper:

Allergic Reactions to: ____

Medications Presently Being Taken: ____

Any past illnesses or other information that would be useful in the event medical treatment is needed: ____

Payment will be made by: ____

(Name of Insurance Company)

____

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(Address of Insurance Company) (City, State, Zip)