Adam Bohac Basketball Camps
Medical Treatment Consent Form

_____, Age_____,
(Print Full Name of Minor)
Social Security Number (if available) _____, will be attending the Adam Bohac Basketball Camp on the campus of the University of Central Missouri on _____. I or assigned chaperones give permission to the Adam Bohac 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:_____ / _____
(Cell) (Home)

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)

_____
(Insurance Company Address)