

**EMPORIA STATE UNIVERSITY**  
**Statement of parent/guardian informed consent**  
**for participation and permission to provide emergency medical services**

**WARNING : ASSUMPTION OF RISK**

I, the undersigned parent/guardian of \_\_\_\_\_, a minor, hereby give my permission for him/her to participate in \_\_\_\_\_. As I sign, I know that vigorous physical  
(Name of camp)

activity presents certain dangers of mild, moderate, or severe injury to my son/daughter. Further, as I sign, I know catastrophic injuries causing death, permanent paralysis or loss of organs can occur as a result of physical activity. I acknowledge that the Camp, Memorial Union, and Emporia State University officials, do not have control over these dangers. My child has been instructed to follow the directions of camp officials.

**PERMISSION TO PARTICIPATE**

I, the undersigned, state that to the best of my knowledge my child is physically capable of participating in a vigorous daily schedule along with rigorous physical activity. Also, I verify the medical history of my child is complete and identifies any factors which might limit his/her physical activity. In consideration of the benefits my child will receive through this camp participation, I hereby release ESU, the Memorial Union Corporation, the State of Kansas, their employees and agents from any liability or claims arising from this activity, except as such claim may be made under the Kansas Tort Claims Act. I give my permission to participate.

**PERMISSION FOR MEDICAL TREATMENT**

I, the undersigned, hereby give permission for my minor child to receive emergency medical treatment or transfer to appropriate medical facility as deemed appropriate by attending physician. Further, I acknowledge reading and understanding the above statements and truthfully completing the medical history portion of this form.

I, the undersigned, provide the following medical history of the above named minor.

- Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S.# \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Home Address \_\_\_\_\_  
Parent or Legal Guardian \_\_\_\_\_ Telephone \_\_\_\_\_  
Full Address \_\_\_\_\_  
Family Physician \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_
- YES NO 1. Allergies  
YES NO 2. Current Medication  
YES NO 3. Major Medical Illness (e.g., anemia, diabetes, epilepsy, bleeding disorders, thyroid, etc.) \_\_\_\_\_  
YES NO 4. Heart Conditions (murmur, heart disease)  
YES NO 5. Respiratory Conditions (asthma, hay fever)  
YES NO 6. Been Knocked Unconscious, How Often, Dates, Recommendation
- YES NO 7. Has There Ever Been A Medical Problem With The Following:  
Eyes \_\_\_\_\_ Kidneys \_\_\_\_\_ Ears \_\_\_\_\_ Hernias \_\_\_\_\_ Testicles
- YES NO 8. Operation or Surgery  
YES NO 9. Fractures (broken bones)  
YES NO 10. Ever Fainted During Exercise. EXPLAIN \_\_\_\_\_ YES  
NO 11. Have All Your Organs? If Not, Which Ones Are Missing?  
YES NO 12. Overnight Hospitalizations (Explain)

STATE OF:

COUNTY OF:

Witness this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_

\_\_\_\_\_  
(Legal Guardian Signature)

\_\_\_\_\_  
(Camp Name)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_,  
in testimony whereof, I have hereunto set my hand and official seal the day and year aforesaid.

\_\_\_\_\_  
Notary Public

My term expires: