Kim Anderson Basketball Camps
Medical Treatment Consent Form

_____Age_____
(Print Full Name of Minor)
Social Security Number (If Available) _____ - _____ - _____, will be attending the Kim Anderson Basketball Camp on the campus of The University of Central Missouri on _____. I or assigned chaperones give permission to the Kim Anderson 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)

_____

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