# WALT BELL, LLC – 2019 APPLICATION

**Overnight Team Football School for Boys Entering Grades 9-12; CEGEP; Prep School and JUCO**

**Registration Fee – $350 per participant**

**$300 per participant if team brings 30+ members**

☐ **June 21-23**

Name: ____________________________________________

Address: ____________________________________________

City, State and Zip: ____________________________________________

High School: ____________________________________________

Participant Cell Phone: ____________________________________________

Participant Email Address: ______________________ Participant Twitter: ______________

Parent/Guardian Name: ______________________ Parent/Guardian Cell Phone: ______________

Grade Entering Fall of 2019: 9 ☐ 10 ☐ 11 ☐ 12 ☐ CEGEP ☐ Prep ☐ JUCO ☐

DOB: ___/___/___ AGE: _____ HEIGHT: ______ WEIGHT: ______

**Position:** Please list one offensive and one defensive position

**Offense:**

**Defense:**

**REGISTRATION**

Register online at www.waltbellfootballschool.com

Online registration closes two days before each football school date.

Make **money order** out to:

**Walt Bell, LLC**

**Refund Policy:** There will be no refunds issued after 1 week prior to event start without a note from a physician. Once a participant is on campus, no refunds will be given for any reason. Online Convenience Fees are non-refundable. NO EXCEPTIONS

**Individuals cannot participate in a football school without a completed Health Form and waiver.**

For more information, contact:

Dan O'Brien

Phone: 413-404-3711

E-mail: waltbellfootballschool@gmail.com

**FOR OFFICE USE ONLY**

PAYMENT RECEIVED: ______________ DATE: ________

MEDICAL RECEIVED: ___ YES ____NO PARTIAL/MISSING: ________

Parent/Guardian Signature: ______________________________ Date: ________________

**Walt Bell Football School**
**Medical & Liability Consent Form**

Name ______________________________________________________ Date of Birth _________________
Phone #:_____________________________________

## Release and Medical Authorization

This is to certify that _______________________________________ has been examined by a physician within the past year, and that he/she was found to be physically able to participate in vigorous physical activity and competitive athletic sports.

Date of last tetanus shot _____________________________________________________________________

Any known allergies _________________________________________________________________________
_______________________________________________________________________________________

Any medical problems we need to be aware of ___________________________________________________
_______________________________________________________________________________________

Any medications you are currently taking _______________________________________________________
_______________________________________________________________________________________

Is an identification band or card carried to alert others to allergy(ies), medical conditions or medication use? ___________
If so, please explain. _________________________________________________________________

## Release of Liability and Medical and Surgical Authorization

In consideration of being permitted to participate in the 2019 Overnight Team Football School by Walt Bell, LLC, I hereby assume the risks of personal injury that may result from program activities. I am knowledgeable about the sport, have previously participated in the sport, and am aware of the potential for injury while participating. Walt Bell, LLC will not be responsible for personal injury that results from negligent acts or omissions of the program employees. As a participant and/or parent or guardian, I do hereby release Walt Bell, LLC, the University of Massachusetts and their employees from all liability for personal injury or property damage which results from causes beyond the control of, and without the fault or negligence of, Walt Bell, LLC or the University of Massachusetts and their employees.

I _________________________ hereby authorize and give my consent to the health care providers to perform upon or administer to ____________________________________________________ (participant's name) any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections and minor operations and procedures.

I understand that Walt Bell, LLC offers an excess insurance for injuries as a result of and that all claims must first be filed with my primary insurance in order to be eligible for this excess coverage. I authorize my insurance company to pay benefits to the health care providers that program employees send my son/daughter to for evaluation and treatment. I authorize the disclosure of medical information to my insurance company and to Walt Bell, LLC's excess carrier for the purpose of a claim.

This permission is good only while the participant is attending the 2019 Overnight Team Football School by Walt Bell, LLC.

Parent or Guardian Signature ________________________________________________ Date _______________

Participant ________________________________________________________________ Date _______________

Insurance Company _________________________________________________________________________

Address __________________________________________________________________________________

_______________________________________________________________________________________

Policy number _____________________________________________________________________________

Policyholder ______________________________________________________________________________

University of Massachusetts Amherst
University Health Services
150 Infirmary Way
Amherst, MA 01003-9288
(413) 577-5000 / *www.umass.edu/uhs*

# MEDICAL AND IMMUNIZATION HISTORY
## PROGRAMS AND CAMPS

Please return form to program: ____________________

______________________________________________

Participant name (print): ______________________________________________
Last First M.I.

## SECTION 1 *(To be completed by parent or guardian.)*

Name: ______________________ Sex: __________ Birth date: __________
Month / Day / Year

Address: ______________________ City/State/Zip: ______________________

Program name: ______________________ Program dates: ______________________

Father: ______________ Phone (day): ______________ Phone (evening): ______________

Mother: ______________ Phone (day): ______________ Phone (evening): ______________

Guardian is: ❑ father ❑ mother ❑ other (name and address): ______________________

(phone number): ______________________

Emergency contact (name, phone number, relationship to participant): ______________________

______________________________________________

Family physician name and address: ______________________

phone number: ______________________

Family dentist name and address: ______________________

phone number: ______________________

Medical insurance company: ______________________ Policy number: ______________________

In case of medical emergency, I hereby give permission to University Health Services (UHS) staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.

______________________ ______________________________

Date Parent/guardian signature

## SECTION 2 **PHYSICAL EXAMINATION:** *Must have been done by a medical provider within the preceding 12 months.*

**MEDICAL HISTORY** (please note significant disorders):

Allergies: ______________ Heart: ______________ Tuberculosis: ______________

______________ Kidney: ______________ Whooping Cough: ______________

Diabetes: ______________ Lung: ______________ Varicella: ______________

Neurological: ______________ Disabilities: ______________ Other: ______________

Pertinent medical history:

Summary of significant treatment program, including names and doses of medications to be used while at program (medications MUST be in a container with the original label):

Participant name: ________________________ Date of birth: ______________

## SECTION 3 REQUIRED IMMUNIZATIONS

### MEASLES, MUMPS AND RUBELLA (MMR) VACCINE

First dose must be after age 12 months; 2 doses required.

MMR #1 ____/____/____ MMR #2 ____/____/____

### POLIO VACCINE

A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mix of (IVP/OPV) was used, four doses are required.

Completed primary series of polio immunizations? ❑ YES ❑ NO

Dates: ____/____/____
____/____/____
____/____/____
____/____/____

### DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE

Minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all campers and staff who will be entering grades seven through 10. For campers and staff who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.)

Completed primary series of DTaP/DTP/DT? ❑ YES ❑ NO

Dates: ____/____/____ ____/____/____ ____/____/____ ____/____/____ Date last Td ____/____/____

### HEPATITIS B

Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

Dose # 1 ____/____/____ Dose #2 ____/____/____ Dose #3____/____/____

### EXCEPTIONS

- RELIGIOUS OBJECTION: The individual must submit a written statement, signed by a parent/guardian if a minor, to the effect that the individual is in good health and stating the reason for such objections.
- MEDICAL: The individual must submit certification by a physician stating that the physical condition of the individual is such that his or her health would be endangered by such immunization.

Health care provider signature and/or stamp: ______________________________

Printed name: ______________________________

Address: ______________________________

______________________________

Phone: ______________________ Date: ______________________

## AUTHORIZATION TO ADMINISTER MEDICATION TO A PARTICIPANT AT THE WALT BELL FOOTBALL SCHOOL

To be completed by parent/guardian:

Name of Participant:______________________________Age: __________

Parent/Guardian Name:__________________________________________

Home Telephone:____________________Business Telephone: ___________________

Emergency Telephone: _______________________

Food/Drug Allergies: _____________________________________________________

Diagnosis: (at parents' discretion):______________________________________

Name of Licensed Prescriber: _____________________________________________

Business Telephone:_________________________Home Telephone: ___________________

Name of Medication:____________________________Dose given at MSS: ____________

Route of administration:______________  Frequency: __________________

Special Directions (e.g. on empty stomach/with water):

_________________________________________________________________

Date Ordered:_____________Duration of Order:____________Quantity Received:__________

Expiration date of Medication Received: ____________________

Special Storage Requirements: __________________________________________________

Specific Precautions:_________________________________________________________

Possible Side Effects/ Adverse Reactions:

_____________________________________

Other medications (at parents' discretion):

_________________________________________

## AUTHORIZATION TO ADMINISTER MEDICATION TO A PARTICIPANT AT THE WALT BELL FOOTBALL SCHOOL

Location where medication administration will occur (Walt Bell Football School to complete):

________________________________________________

I hereby authorize Walt Bell Football School to administer to my child,

_________________________________________(NAME OF CHILD)

the medication(s) listed on page 1 of this authorization, in accordance with 105 CMR 430.160.

105 CMR 430.160(A)
Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filing, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statement, if any, contained in such a prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160 (C)
Medication shall only be administered by the health supervisor* or by a licensed healthcare professional authorized to administer prescription medications. The healthcare consultants shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed healthcare professional authorized to administer prescription medications, the administration of medication shall be under the professional oversight of the healthcare consultant. Medication prescribed for campers brought from home and shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D)
When no longer needed, medication shall be returned to a parent of or guardian wherever possible. If the medication cannot be returned, it shall be destroyed.

*Health Supervisor: A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross first aid (or its equivalent) and CPR, trained in the administration of medications, and under the professional oversight of a licensed healthcare professional authorized to administer prescription medications.

Parent/Guardian Signature: __________________________________________

Date: _________________________

# PARENT PERMISSION FORM

## APPROVAL FOR SELF-ADMINISTERED MEDICATION

As the parent or guardian of ________________________________, ___
Participant Name

I give permission for the above listed participant to have readily available (carry or possess outside of the regular supervision of the event's health staff) and self-administer as medically necessary, the following specific medications and devices: (Check all that apply)

a. Asthma Inhaler

b. Epinephrine Pen

c. Fingerstick glucose monitoring equipment

d. Insulin and injection syringes

e. Insulin pump

I confirm that the participant has the knowledge and the skills to have readily available and to safely self-administer the above medication/devices during the event, and will be bringing all necessary medications and supplies with them to the event.

______________________________________________________________________

Parent or Guardian signature Date

# 2019 Walt Bell Football School
# Participant Pickup Authorization Form

*Names not placed on this list will not be allowed to pick up the participant*

**PARTICIPANT'S NAME** (please print): _______________________________________________

**SCHOOL** (please print): ___________________________________________________________

**DATES ATTENDING** (please list ALL that apply):

**PARENT/GUARDIAN'S NAME** (please print):___________________________________________

**PARENT/GUARDIAN'S SIGNATURE**: ______________________________ **DATE**: ____________

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**AUTHORIZED INDIVIDUALS TO PICK-UP THE NAMED PARTICIPANT** (please print):

1. (name): ____________________________________ (phone #): ______________________________

2. (name): ____________________________________ (phone #): ______________________________

3. (name): ____________________________________ (phone #): ______________________________

4. (name): ____________________________________ (phone #): ______________________________

5. (name): ____________________________________ (phone #): ______________________________

**INDIVIDUALS NOT AUTHORIZED TO PICK-UP THE NAMED PARTICIPANT** (please print):

1. (name): ____________________________________

2. (name): ____________________________________

3. (name): ____________________________________

4. (name): ____________________________________

5. (name): ____________________________________