# WALT BELL, LLC – 2019 APPLICATION

**Overnight Team Football School for Boys Entering Grades 9-12; CEGEP; Prep School and JUCO**
**Registration Fee – $225 per participant**
**$200 per participant if team brings 30+ members**
**$150 commuter rate**

☐ **Saturday, June 22-23**

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

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

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

### 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): _____