



Dear Camper,

Thank you for completing the required health and insurance forms for your child. Please send these forms to Anne Rueppel, our Camp Administrator, **within 2 weeks of registering**. We greatly appreciate your prompt attention to these important forms. The completed forms must be received in order for your camper to attend.

Below are the details for mailing and emailing the required forms:

- 1) Scan and email forms to Anne Rueppel – tpsc@kenyon.edu (PREFERRED)
- 2) Send via postal mail to:

Total Performance Swim Camp
221 Duff St.
Gambier, Ohio 43022

If you have any questions about the forms or need any additional information, please email Anne - tpsc@kenyon.edu We look forward to working with your camper this summer!

Sincerely,

Anne Rueppel and the Total Performance Staff

Mail forms to:
Total Performance Swim Camp
221 Duff St.
Gambier, Ohio 43022

Scan & Email forms: tpsc@kenyon.edu



HEALTH / MEDICAL FORM:

Please complete this form in its entirety. This required information will be helpful in the unlikely event of an accident or sudden illness. **Due: 2 weeks after registration**

Check the box for your camp:

Masters Swim Camp

Camper name: _____

Physician: _____

Physician Address: _____

Physician Phone: _____

1) Allergies (check box if "YES"):

- Hay Fever _____
- Insect Stings _____
- Penicillin or Medications (if "YES" please describe): _____
- Food allergies – ie: gluten, peanuts, etc. (if "YES," please describe): _____

2) Diseases/Conditions (check box if "YES" and give approx. dates):

- Chicken Pox _____
- Asthma _____
- Mononucleosis (Mono) _____
- Depression/Anxiety _____
- Other _____

3) Please list any health conditions/injuries that may affect your participation in any camp activities. What precautionary measures must be taken?

4) Immunizations: I certify that myself is up-to-date on all pediatrician/CDC recommended vaccines.

YES / NO (circle one)

5) Vaccines: Please give approximate dates for the following vaccinations (If not applicable to your child based on age please leave blank)

Dtap/TD/Tdap (Tetanus, Diptheria, Pertusis vaccine) _____

Tetanus booster _____

Meningococal Conjugate Vaccine (MCV) _____


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6) **Signature:** I hereby state that, to the best of my knowledge, my answers to the above questions are correct.


Signature of Participant _____ Date _____ 

HEALTH / MEDICAL FORM (PAGE 2): *Every camper must have this form on file. Due: 2 weeks after registration*

7) **READINESS TO COMPETE:** The Participant(s) and undersigned parent/guardian of the Participant(s) agree that the Participant(s) will only participate in those Total Performance Swim Camp activities for which the Participant(s) is/are physically and psychologically prepared to compete. By signing this Agreement we represent that the Participant(s) has/have been examined by a physician and has/have been cleared to participate in a competitive sports camp, that we know the Participant(s) to be physically and psychologically prepared to compete, and that we are unaware of any physical or psychological condition that renders or may in the future render the Participant(s) unfit to participate in a Total Performance Swim Camp activity. Furthermore, we understand that Total Performance Swim Camps and Kenyon College reserves the right to remove the Participant(s) from participation in any camp activity or from the camp entirely, without reimbursement, if the staff determines the safety and overall well-being of the Participant(s) or other participants is compromised by the his/her/their physical or psychological readiness to compete.

Signature of Participant _____ Date _____ 

8) **MEDICAL CONSENT TO TREAT:** Total Performance Swim Camps will make every effort to contact me in case of an emergency. I give my permission to Total Performance Swim Camps and the medical staff of its choice to administer any medications authorized by me or a designated parent/guardian and to provide and arrange for any necessary medical treatment to my child while at Total Performance Swim Camps, including onsite and offsite emergency care. I accept responsibility for the costs of all such medical treatment.

Signature of Participant _____ Date _____ 

9) **INSURANCE INFORMATION:**

Policyholder's Name: _____ Relationship to Camper: _____

Insurance Company: _____ Effective Date: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____

Group # / ID #: _____ Policy #: _____

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Should I (camper) require medical attention, I understand that I am responsible for paying any costs not covered by insurance.

Signature of Participant _____ Date _____



Emergency Contact:

Name: _____



Phone Number: _____

Relationship to Participant: _____

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