

Willamette University Volleyball Camps Medical Waiver

Last Name _____ First _____ Age ____ Gender ____
Date of Birth _____ Grade _____
Parent/guardian _____
Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Relation _____
Emergency Contact Phone # _____
Health Care Carrier _____
Name of Member _____ Policy/Group Number _____

Name of Camp and dates _____

Health History (check/explain)

Allergies (check)

<input type="checkbox"/> Frequent Ear Infections _____	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Disease/Defect _____	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Mononucleosis _____	<input type="checkbox"/> Food (specify) _____
<input type="checkbox"/> Bleeding/Clotting Disorder _____	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Convulsions _____	_____
<input type="checkbox"/> Operations _____	_____
<input type="checkbox"/> Dietary Modification _____	_____

Family Physician _____ Phone # _____

May the camper have Tylenol (acetaminophen)? Yes No

The information stated above is correct as far as I know, and the individual herein described as "camper" has permission to participate in all camp activities except as noted. I hereby give permission to the medical personnel selected by the Willamette Volleyball Camp Staff to order x-rays, routine tests, treatment and necessary transportation for the above named camper in the event that I cannot be reached in an emergency. I hereby grant permission to the medical personnel selected by Willamette University to secure and administer treatment including hospitalization for the above named camper. I FURTHER UNDERSTAND, THAT IF I DO NOT HAVE MEDICAL INSURANCE, I WILL BE RESPONSIBLE FOR ANY MEDICAL COSTS INCURRED.

Parent/Guardian Authorization _____

Date _____