

LMU Volleyball Camps Medical Waiver

Last Name _____ First Name _____ Age _____ Gender _____
Social Security Number _____ Date of Birth _____
Session Dates _____
Parent/Guardian _____
Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Relation _____
Emergency Contact Phone Number (Home) _____ (Work) _____
Health Care Carrier _____
Name of Member _____ Policy/Group Number _____
Sport Camp _____

HEALTH HISTORY (Check/Explain)

Frequent Ear Infections _____
Heart Disease/Defect _____
Diabetes _____
Hypertension _____
Mononucleosis _____
Bleeding/Clotting Disorders _____
Bed wetting problem _____
Sleep Walker _____
Convulsions _____
Other _____
Operations/Serious Illness _____
Disability/Recurring Illness _____
Dietary Modification _____

DISEASES

Chicken Pox _____
Mumps _____
Measles _____
German Measles _____

IMMUNIZATION

(Check if up to date)

DPT _____
Rubella _____
Tetanus _____
Oral Polio _____
Measles _____
Mumps _____

ALLERGIES (Check/Explain)

Hay Fever _____
Asthma _____
Insect Stings _____
Penicillin _____
Food (Please Specify) _____

Other _____
Family Physician _____
Phone _____
Family Dentist _____
Phone _____

Has camper been exposed to a communicable disease within the last 21 days?
Yes ___ No ___ (If Yes, what disease? _____)

May camper have Tylenol (acetaminophen)? Yes ___ No ___

MEDICAL RELEASE INFORMATION

Type of Medication _____
How to Administer _____

Purpose of Medication _____
Other Comments _____

Please note that the medication must be in original container with the label still intact

PARENT/GUARDIAN AUTHORIZATION

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 LMU 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 LMU 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 OR ADULT CAMPER

SIGNATURE _____ DATE _____

Please fax or mail form

FAX – (310) 338-2765 Attention: LMU Volleyball Camps

Mail:

Loyola Marymount University

Attn: Athletics/Women's Volleyball

1 LMU Drive, MS 8235

Los Angeles, CA 90045