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 wit 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) 338-5915 Attention: LMU Volleyball Camps
Mail:
Loyola Marymount University
Attn: Athletics/Women's Volleyball
1 LMU Drive, MS 8235
Los Angeles, CA 90045