FSCVB Camps

MEDICAL HISTORY AND RELEASE FORM

Please complete **all** sections of this form. The parent/guardian **must** sign in all appropriate areas. By signing this form, the participant and parent/guardian affirms they have read and understand it.

LAST NAME ____________ FIRST NAME ____________ MI ______ (CIRCLE ONE) M F

STREET ADDRESS ________________________________

CITY ____________ STATE ____________ ZIP CODE ____________

___/___/___ BIRTH DATE ______ AGE ______ SOCIAL SECURITY NO. ______ HEIGHT WEIGHT ______

The Participant,________________________, has permission to participate in the FSCVB Camps Program. I certify that the participant has full medical insurance with the company listed below and is physically fit to engage in the activities of the program. I approve of the leaders and coaches associated with this program and recognize that they will serve to the best of their ability. I understand and agree that this document will be kept in the possession of authorized FSCVB Camps personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

MUST SIGN:________________________ Relationship:________________________

PARENT/GUARDIAN SIGNATURE

Print Name:________________________ ______ ______ ______

PARENT/GUARDIAN HOME PHONE CELL PHONE WORK PHONE

STREET ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

INSURANCE COMPANY ____________ GROUP POLICY # ____________

DOES THIS POLICY COVER SPORTS RELATED ACCIDENTS? (CIRCLE ONE) YES NO

MEDICAL RELEASE:

If my son or daughter should become ill or sustain an injury during his or her activities of the volleyball program, I hereby authorize you to obtain emergency medical/dental care.

SIGN: ________________________ Date: ________________

PARENT/GUARDIAN SIGNATURE

I do not authorize emergency medical/dental care for my son or daughter.

SIGN: ________________________ Date: ________________

PARENT/GUARDIAN SIGNATURE

MEDICAL HISTORY

	YES OR NO		DATE	PLEASE SPECIFY
ALLERGIES	Y	N	___________	___________________________
ASTHMA	Y	N	___________	___________________________
DIABETES	Y	N	___________	___________________________
EPILEPSY	Y	N	___________	___________________________
HEADACHES	Y	N	___________	___________________________
HEART	Y	N	___________	___________________________
KIDNEY DISEASE	Y	N	___________	___________________________
MOTION SICKNESS	Y	N	___________	___________________________
INJURIES:				
ANKLE	Y	N	___________	___________________________
KNEE	Y	N	___________	___________________________
BACK	Y	N	___________	___________________________
HEAD/NECK	Y	N	___________	___________________________
SHOULDER	Y	N	___________	___________________________
ELBOW	Y	N	___________	___________________________
WRIST	Y	N	___________	___________________________
HAND	Y	N	___________	___________________________
FINGER	Y	N	___________	___________________________
OTHER	Y	N	___________	___________________________

IMMUNIZATIONS (please state month and year):

Tetanus____________________ Polio_____________________ Measles (Rubella)______________________

Is the participant taking any medications? _____NO _______YES

If yes, please name the drug(s), dosage and frequency needed:

____

Is there any psycho-social or physical condition for which the participant is currently under professional care?

_______NO _______YES

Please list any injuries the participant has suffered in the last two months:____________________________

____

Elaborate on any other medical conditions:____

____

STATE OF________________________

COUNTY OF______________________

SWORN TO BEFORE ME, A NOTARY REPUBLIC, BY SAID_____________________________PERSONALLY KNOW TO ME THIS________________DAY OF_____________,20____.

____NOTARY REPUBLIC

MY COMMISSION EXPIRES_____________________________