

Moravian College Volleyball Camp Health Form

This form must be completed and signed by the camper's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session.

CAMPER INFORMATION

Camper's Name _____
Permanent Address _____ Date of Birth _____
City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first: Backup contact (relative or friend):
Name _____ Name _____
Relation to camper _____ Relation to camper _____
Daytime Phone _____ Daytime Phone _____

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: ___ Yes ___ No

If yes, provide the following information:

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____
Address _____ Relation to Camper _____
City/State/Zip _____
P.H.'s Employer _____
Insurance Company _____
Policy # _____ Plan # _____

DOES THE CAMPER CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: _____
Food allergies: _____
Allergies to insect bites: _____
Special dietary needs: _____
Asthma: _____
Frequent headaches: _____
Dizziness or seizures: _____
LIST: Other health problems: _____

Limitations of Activities: _____

Medications the camper is currently taking: _____

(Please note: Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, she must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain: _____ yes _____ no

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Moravian College Volleyball Camp staff to seek medical treatment for the camper as they see necessary. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the camper’s session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the camp staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Camp staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Camp staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

Legal Guardian’s Signature

Print Name

Date

(Please mail this and the Health form and waiver and release statement with balance – thank you)