MEDICAL HISTORY AND RELEASE

This information will be kept by Head Trainer or Dorm Counselor and consulted anytime a medical problem arises during Volleyball Camp. Note: Medications brought from home that are not listed on this form will not be permitted.

Name _____Date of Birth_____/_____/_____Phone_(___)_____

Address_____City_____State_____Zip_____

Date of last medical examination by licensed physician_____

Date of Last Immunizations:_____

Allergies, Identify_____

Food Allergies, Identify_____

Are there any condition(s) that will restrict activity?_____If yes, explain and give instructions_____

_____

If taking regular medication, give name(s) of medication and directions for dosage:_____

_____

Please check if subject to: Fainting_____ Nosebleeds_____ Headaches _____Other_____

** If necessary, administer: Asprin____and/or Tylenol____. How much and how often?_____

_____

Vision corrected by: glasses _____contact lenses_____

Teeth corrected by braces_____headgear_____retainers_____other_____

Exceptions _____

GENERAL INFORMATION

We will utilize the emergency rooms of Covenant Hospital or University Medical Center, unless you specify otherwise. If hospital treatment is necessary, we will immediately contact the individuals listed on the other side of this form. No Medical/Hospitalization Insurance is carried through this program. Parents/guardians will be billed for any and all medical expenses incurred by their children during the Tony Graystone Volleyball Camp, LLC including but not limited to emergency room costs, physician fees, X-rays, medication, pharmaceuticals and related expenses.

CONSENT TO TREAT

I authorize program administrators of Tony Graystone Volleyball Camp, LLC to sanction medical treatment for (Participant's name)_____. I understand that NO medical/hospitalization insurance is carried through Tony Graystone Volleyball Camp, LLC and agree to be responsible for all medical expenses incurred by my child while attending Tony Graystone Volleyball Camp, LLC.

Parent Signature _____

INSURANCE AND EMERGENCY INFORMATION

Please fill in every line. If necessary, write N/A for Not Applicable.

Parents' Medical/Hospitalization Carrier (give name of insurance company, not agent):

_____Policy Number_____

Family Physician_____

_____ ( )_____( )_____
Office Address Office Phone Home Phone

Preferred Lubbock Physician (optional)_____

_____ ( )_____( )_____
Office Address Office Phone Home Phone

IN CASE OF EMERGENCY CONTACT:

_____
Parent/Guardian Address City/State Zip Code

( )_____ ( )_____
Home Phone Office Phone

If the above cannot be contacted, call (list at least two):

1) _____
Name Address City/State/Zip

( )_____( )_____
Home Phone Office Phone Relationship to participant

2) _____
Name Address City/State/Zip

( )_____( )_____
Home Phone Office Phone Relationship to participant

3) _____
Name Address City/State/Zip

( )_____( )_____
Home Phone Office Phone Relationship to participant