WEST VIRGINIA UNIVERSITY ATHLETICS CAMPS/CLINICS

Camp Health Form

Name_____
Last First Middle Initial
Birth Date_____ Sex_____ Age_____

Parent or Guardian_____

Home Address_____
Street and Number
_____
City State Zip

Phone ( )_____

If parent or guardian above is not available in an emergency, please call:

1._____ Phone ( )_____
2._____ Phone ( )_____

Health History (Check, giving approximate dates)

Ear Infections	_____	Hay Fever	_____	Heat Illness	____
Ivy Poisoning	_____	Asthma	_____	Menstrual Cramps	____
Convulsions	_____	Insect Bites	_____	High Blood Pressure	____
Diabetes	_____	Food Allergies	_____		
Behavior/ADD/ADHD	_____	Drug Allergies	_____		

Operations or Serious Injuries (Dates)_____
_____
_____

Insurance Company Name: _____

Policy Number_____ Group Number_____

Policy Holder Name_____

Parent or Guardian Signature _____

Important: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

Parent's Authorization

This health history is correct as best as I know, and I hereby give permission for the person herein described to engage in all prescribed camp activities, except as indicated below

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected at the camp director's discretion to hospitalize, secure treatment, and order injection, anesthesia or surgery for my child.

Signature_____ Date_____

Restrictions/Limitations While at This Camp for This Camper:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

A sports camp / clinic participant shall not be permitted to attend a particular camp unless this camp health form, or a similar document with a doctor's signature is completed and returned to the appropriate camp staff no later than the day of registration.

Blood Pressure _____ Pulse _____ Height _____ Weight _____

Check abnormalities or elaborate below:

Head and Neck _____	Genitalia _____
Heart _____	Hernia _____
Lungs _____	Extremities _____
Abdomen _____	Neurologic _____

Remarks: _____
_____
_____
_____

Doctor's Name (Print): _____

Doctor's Signature: _____ Date: _____