Please fill out this form completely. It is important for the provision of proper medical care. The section Marked "Physician's Comments" need only be completed if the participant has a major health problem. When older participants are seen for minor illnesses or injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the physician will try to contact the parents to inform them of the problem and discuss the treatment. Occasionally, we are unable to reach parents immediately to inform them of a serious problem. The parent's signature on the medical treatment authorization allows us to go ahead with treatment in these circumstances. The Training Room staff, Porter Memorial Hospital or the Athletics Office will continue to call until contact is made with the parent or guardian. **THIS FORM MUST BE ON FILE BEFORE YOUR CHILD CAN PARTICIPATE!!!**

NAME OF CAMP:_____ **CAMP DATES**:_____

MEDICAL HISTORY

1. **PERSONAL INFORMATION** (PLEASE PRINT)

Name_____ Sex: ☐ Male ☐ Female

Home Address_____
Street City State Zip

Phone_____ Date of Birth_____ Age_____

IN CASE OF EMERGENCY NOTIFY:_____
NAME OF PARENT OR NEXT OF KIN RELATIONSHIP

Address_____

Home Phone_____ Business Phone_____ Cell Phone_____

Family Physician_____ Phone_____

Address_____

2. **FAMILY HISTORY** (PLEASE CONSULT PARENTS)
Do you have a family history of: (please circle)

Diabetes Tuberculosis Cancer Heart Disease Kidney Disease Migraine

3. **PERSONAL HISTORY**
Immunization Record (include dates, if possible, if not please specify if shots are current)

DPT_____ MMR_____ POLIO_____

Most Recent TETANUS BOOSTER:_____

Allergies – Particularly to medications (please list)

Have you had any of the following: (please circle)

Asthma Bleeding Disorder Diabetes Heart Condition Kidney Disease

Please list any of the following you have had and note the dates:

Head Injuries _____

Fractures (please specify)_____

Surgery _____

Hospitalization _____

List any medications you are currently taking and include directions:_____

_____

4. **PHYSICIAN'S COMMENTS** (OPTIONS)

Note to physician: Please provide a brief history of the camper's problem, any pertinent physical findings or laboratory values, and a description of therapy. Also please list any ways in which we may help to care for your patient. Thank you.

5. **INSURANCE INFORMATION** (participant **MUST** be covered by a health insurance policy)

Name of Company_____

Company Address_____

Group Number_____

6. **MEDICAL TREATMENT AUTHORIZATION AND LIABILITY RELEASE**

I, the undersigned parent or guardian, do hereby grant my permission for my daughter/son to attend the Valparaiso University Sports Camp in all activities thereof. In the event of an injury or illness during these activities, even if I cannot be directly contacted at the time, I hereby authorize Porter Memorial Hospital to provide the medical treatment deemed necessary. I hereby release Valparaiso University and Porter Memorial Hospital and their agents, employees, and representatives from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for medical care and treatment will be forwarded to my insurance company or me, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity there is a possibility of physical injury or illness and that my daughter/son is assuming the risk of injury by his/her participation. I further authorize the program director of his/her staff, or the training room staff to administer non-prescription analgesics for minor problems such as headaches, etc.

Parent / Guardian signature_____ Date_____