Illinois State Volleyball Camps

2018 Health History Form

PLEASE BRING THIS COMPLETED FORM WITH YOU TO CAMP CHECK-IN

Camper Name:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Cell Phone:_____ Home/Work Phone:_____

Please circle Yes or No if you have a history of any of the following:

Chronic/Recurrent Injury	Y N	Bleeding/Clotting Disorder	Y N	Asthma/Lung Disorder	Y N
Diabetes	Y N	Illness lasting more than 1 wk	Y N	Physical Limitations	Y N
Hearing/Vision Impairment	Y N	Heart Disease	Y N	Seizure Disorder	Y N
Head Injury/Concussion	Y N	Hypertension	Y N	Stroke	Y N
Use of Protective Equipment/Brace	Y N	Kidney Disease	Y N	Dizziness/Fainting w/exercise	Y N

Other_____

Please give a brief description of any above items that were circled YES:_____

_____

_____

Please list any Current Injuries: (For injuries receiving medical care, please include a doctor's note clearing the athlete for participation)

Are you currently taking any medication – if so, what type, dose, and frequency (please list):

_____

Are you allergic to any prescription of over the counter medications? Do you have any food, insect, or pollen allergies?

Proof of Insurance is required to participate in Redbird Volleyball Camp

I, _____, acknowledge that I have chosen to participate in Illinois State Volleyball Camps, LLC. at Illinois State University and that I currently carry medical insurance. I acknowledge the risks of any and all damages, injuries (including death), or losses that I may sustain or incur while attending and participating in Illinois State Volleyball Camps, LLC. I give my consent to receive emergency medical treatment in the event of injury or illness and agree to be responsible for all costs associated with my transportation and treatment.

Parent or Guardian Signature: _____ Date: _____

Adult Participant Signature: _____ Date: _____

Printed Name: _____

ILLINOIS STATE VOLLEYBALL CAMPS, LLC. – LEAH JOHNSON

For contact and other camp information please visit:

WWW.ILLINOISSTATEVOLLEYBALLCAMPS.COM