



VOLLEYBALL CAMP Medical Information Release & Waiver

The undersigned, in partial consideration for the participation of his/her child/children in The University of Toledo Volleyball Camps does hereby waive, release and forever discharge the University of Toledo, its agents and employees from any and all claims of injury or property damage sustained by the participant child/children arising from or out of said participation. In addition, the undersigned does hereby agree to indemnify and save harmless the University of Toledo, its agents and employees from all claims or demands whatsoever arising from injuries or property damage resulting from the participation of his/her children in the above-mentioned activity, including but not limited to negligence of said employees or agents.

Child's Name

Signature of Parent/Guardian (Required for participation of child) _____
Date

HEALTH HISTORY

Please describe below or attach any other pertinent medical information which you feel the camp medical staff may need in the event treatment or emergency care is needed (allergies, past emergencies, etc.). Does the child frequently have problems with any of the following:

| | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> |
|-------------------------|------------|-----------|-------------------|------------|-----------|
| Nosebleeds | _____ | _____ | Fainting | _____ | _____ |
| Stomach Cramps | _____ | _____ | Allergies | _____ | _____ |
| Diabetes | _____ | _____ | Muscles/Joints | _____ | _____ |
| Sore Throats | _____ | _____ | Vision | _____ | _____ |
| Infections | _____ | _____ | Orthopedic Braces | _____ | _____ |
| Epilepsy | _____ | _____ | Hearing | _____ | _____ |
| Heart Conditions | _____ | _____ | Other | _____ | _____ |
| High/Low Blood Pressure | _____ | _____ | Explain: _____ | | |
| Breathing | _____ | _____ | | | |

If yes to any of the above, please explain: _____

INSURANCE INFORMATION

It is important for your child to have health insurance information with them at camp. This is very helpful should the need arise for medical attention during camp. Please help us by providing the following information:

Insurance Company: _____
Address: _____
City/State/Zip: _____
Subscriber's Name: _____
Subscriber's Policy Number(s): _____

Is a claim form required by the insurance company? Yes ___ No ___ (If yes, attach copy.)

Your signature as a parent or guardian below grants your permission for a qualified physician, athletic trainer and/or hospital emergency room to administer necessary healthcare to your child in the case of an accident or emergency. This permission includes admission to area hospitals if necessary.

Parent/Guardian Signature _____
Please print name here