**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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Doctor’s Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_