



**2018 SAINT LOUIS VOLLEYBALL CAMP MEDICAL INFORMATION FORM**  
**Due 2 Weeks Prior to Start of Camp**



**CAMPER INFORMATION:**

CAMPER NAME: \_\_\_\_\_ CAMP DATES: \_\_\_\_\_  
 CAMPER ADDRESS: \_\_\_\_\_ DATE: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**MEDICAL HISTORY (To be completed by parent/guardian)**

A. Allergy (drugs, food, asthma, etc.)	Y _____	N _____
B. Pre-Existing injury currently under treatment	Y _____	N _____
C. Medical conditions currently under treatment	Y _____	N _____
D. Birth Deformities (one kidney, etc.)	Y _____	N _____
E. Fractures or other disability type injuries	Y _____	N _____
F. Mental disorders or convulsion	Y _____	N _____
G. Known past illness for more than one week's duration	Y _____	N _____
H. Concussion or head injury	Y _____	N _____

PLEASE INCLUDE AN EXPLANATION OF ANY QUESTIONS ABOVE ANSWERED "YES."

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

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DENTIST'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**INSURANCE INFORMATION:**

MEDICAL INSURANCE: \_\_\_\_\_ POLICY#: \_\_\_\_\_  
 ADDRESS OF INSURANCE COMPANY: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 INSURANCE COMPANY PHONE: \_\_\_\_\_

**EMERGENCY INFORMATION:**

Parent or Guardian:

(1) \_\_\_\_\_ PHONE: \_\_\_\_\_  
 Relation to Camper: \_\_\_\_\_ ALT. PHONE: \_\_\_\_\_  
 (2) \_\_\_\_\_ PHONE: \_\_\_\_\_  
 Relation to Camper: \_\_\_\_\_ ALT. PHONE: \_\_\_\_\_

PREFERRED EMERGENCY CONTACT (Circle One): (1) (2)

Submission Options:

1. Mail to Saint Louis Volleyball Camp, PO Box 220271, St. Louis MO 63122
2. Email to [info@saintlouisvolleyballcamp.com](mailto:info@saintlouisvolleyballcamp.com)
3. Scan and upload to your online account
4. Fax to 314-977-3178, Attn: Volleyball Camp